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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Youth in the Carribbean

Parents of the Handicapped

Psychotherapy for Families

A Staff Development Plan

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ANTICIPATION. These youngsters, gathered on a Philadelphia sidewalk, are awaiting the appearance of the Play Parade, a mobile unit equipped with toys, games, craft materials, and volunteer teenage recreation leaders, due in their block for the day. The trailer is part of a group of similar units which, under the auspices of the Friends Neighborhood Guild, a United Fund community center, move through this "inner city" neighborhood in the summertime to bring constructive fun to children whose playground is the street.

In addition to serving with the Jewish Family Service, which he joined 5 years ago, Dr. Nathan W. Ackerman holds the posts of clinical professor of psychiatry at Columbia University and lecturer at the New York School of Social Work. He also directs the newly organized Family Institute described in his article. Previously, for 14 years, he was chief psychiatrist with the Jewish Board of Guardians, New York, and director of its Child Development Center.

The activities for parents of handicapped children described by Aline B. Auerbach are part of the latest in a series of programs conducted by the Child Study Association to train professional workers—in this case, social workers—to serve as leaders in parent education groups. The author, who has done graduate work at Columbia University's Teachers College and the New York School of Social Work, is a specialist in parent education and has written numerous pamphlets and articles for parents and professional workers.

Carol H. Meyer joined the New York City welfare department after 4 years on the faculty of the New York University Graduate School of Social Service. A former caseworker with the Community Service Society, she focused her interest in family diagnosis before going into public welfare. She has both a master's and doctorate from the New York School of Social Work, Columbia University.

Since receiving his Ph. D. in psychology at the State University of Iowa, John H. Rohrer has been doing experimental studies on social learning and on interrelationships between culture and personality, and, in recent years, on personality disorders. When directing the study described here, he was heading the Urban Life Research Institute for Tulane University. He joined the staff of Georgetown University School of Medicine in 1957.

Prior to coming to the Children's Bureau in 1949, Martin Gula directed a treatment residence for disturbed children and, before that, an experimental diagnostic and treatment center for adolescent boys. He has also been rural social worker for a State welfare agency, a psychiatric clinic caseworker in a State training school, a settlement house worker, and a faculty member at the schools of social work at Loyola University and the University of Chicago. He has graduate degrees in both social work and education.

◀ *the authors*

YOUTH IN THE CARIBBEAN –REACHING FOR MATURITY

KATHRYN CLOSE

ARE ADOLESCENTS in a Caribbean island the same as anywhere else in the world? This question kept intruding itself into the Conference on the Adolescent in the Changing Caribbean, held April 4–11, at the University College of the West Indies, Mona, Jamaica. Among the 198 participants, 20 of them adolescents and young adults, from 12 Caribbean islands and the continental United States, the consensus seemed to be "yes," but—except perhaps among the young people themselves—a "yes" qualified by recognition of the differences created by cultural expectations, by opportunities, and by frustrations. More than once it was suggested that psychological adolescence in itself is a new phenomenon, created by the industrial revolution and intensified in areas where old cultures are giving way to new, with resulting conflicts among the generations.

This conference, the third Caribbean conference for mental health, was a sequel to the Conference on Children of the Caribbean—Their Mental Health Needs, held 2 years ago in St. Thomas, U.S. Virgin Islands, under the auspices of the World Federation for Mental Health and the Virgin Islands and Puerto Rico Governments. The Virgin Islands conference had resulted in the formation on the spot of the Caribbean Federation for Mental Health and later of the Jamaica Association for Mental Health, the cosponsors of this year's meeting. The First Caribbean Conference for Mental Health, held in Aruba, Netherlands Antilles in 1957 was focused on alcoholism.

The question might be raised as to why a mental health conference in the Caribbean. What do these scattered islands of the Greater and Lesser Antilles, some of them more than a thousand miles from each other, have in common besides their tropical beauty? Not language. Four different languages—English, French, Dutch, Spanish—were the official languages of the islanders who attended the conference. Not political structure. Haiti was the only completely independent country with participants at the Jamaica conference. The islands of the West Indian Federation, represented there by Jamaica, Trinidad, Barbados, Dominica, and Antigua, are soon slated for independence. Puerto Rico is a commonwealth economically and politically tied to the United States; the U.S. Virgin Islands is a territory of the United States; Martinique and Guadeloupe are Departments of France; Curaçao and Aruba are linked to the Netherlands in defense and foreign policy. (Cuba and the Dominican Republic, also invited to the conference, did not send representatives.)

What all these islands have long had in common is widespread poverty, a rapid population increase, a low level of education among the masses of the people, and a heritage of mixed cultures strongly influenced (except in Puerto Rico) by the African origins of the great majority of the people and the insults of slavery and its aftermath. What they have in common today, in addition, is an obvious ferment among the people, especially the young, to partake of the good life and to run their own affairs. One of the most frequently repeated phrases at the conference was "the rising expectations of the masses." Whether these expectations are to result in healthy achievement or frustration and despair, and perhaps even explosion, was the haunting question that throbbed like a drum accompaniment throughout the conference.

The structure of the conference included daily plenary and work group sessions, the latter mixed

professionally and nationally, and a few intra-professional meetings. While a few "outside" experts from England, Canada, The Netherlands, and the United States spoke at the plenary sessions and served as consultants and leaders in the group meetings, the large majority of speakers and other participants, were islanders—psychiatrists, medical practitioners, nurses, social workers, educators, sociologists, psychologists, anthropologists, government administrators, clergymen, law enforcement agents, and students. In this respect, the conference was, in fact, more truly a Caribbean conference than its Virgin Islands predecessor.

This was the first of the three Caribbean mental health conferences to invite young people as participants. The 20 young men and women—all students at secondary schools or universities—were self-possessed and articulate, speaking out unhesitatingly about the problems bothering them, and often exerting an influence to keep the conference action-oriented. While perhaps they represented only the well-educated "cream" of young people in these economically depressed islands, they at least knew what *they* wanted. Most persistent of their cries: "Give us more freedom so that we can become independently responsible."

So many psychiatrists attended the conference that the visitor's first impression was apt to be that psychiatrists are plentiful in the Caribbean area, until he realized that some countries had sent *all* their psychiatrists to the meeting—in the case of Haiti, for example, two. Yet there was little talk of isolated psychiatric theory. The Caribbean psychiatrists, as well as other professional people of the islands, were obviously culture conscious, their concern being how to ameliorate the conditions in the island cultures that prevent the healthy development of adolescents.

When the psychiatrists did discuss treatment techniques together, they talked about ways of adapting what they had learned "elsewhere" to their patients in the islands. For example, among a people immersed in magical cults how is it possible to tell where superstition ends and hallucination begins? In Haiti, it was reported, the psychiatrist must sometimes work through the voodoo priest.

The assumption of the conference was that psychiatry cannot solve the mental health problem alone, that the major task of preventing mental and emotional disturbance can best be accomplished by spreading mental health understanding and techniques among those who come in daily contact with parents and children. A few participants even expressed the opinion that mental health—which a Dutch psychiatrist [1] defined as "the promotion of optimal living"—was not the job of psychiatrists at all, but of psychologists, sociologists, teachers, and even voters, who must bring about conditions conducive to healthy living.

Adolescence

Descriptions of adolescence per se came from many sources—psychiatrists, psychologists, anthropologists, educators, public health nurses, and community development workers. There seemed to be general agreement that adolescence today is a period of "sturm und drang," a time when the young person is reaching out for freedom, but still needs the security of his parents' affection, when sexual urges are strong, a time when friendships are extremely important, when adult models have a critical influence on the shape of things to come, and when the need to feel needed in the world is paramount.

Over and over the point was made, by experts and by adolescents themselves, that much of the adolescent's inner confusion is created by adults who tell him he is "acting like a child" but will not give him the independence of an adult. Psychiatrists, psychologists, and anthropologists emphasized the importance of the young person's having a delineated role—of, as a Chicago psychiatrist [2] expressed it, his "knowing who he is and where he is going"—and they pointed to the failure of the modern world to provide this.

An educator from Jamaica,[3] on the other hand, maintained that in the "solitary" struggle to grow up, an adolescent must find his own way and "have the opportunity to make mistakes." This seemed to cause considerable anxiety among some of the conference participants concerned with the obligation of adults to guide the young. A community development worker from Trinidad [4] asked whether there were not such things as truth, freedom, justice, sexual morality, "about which we adults cannot allow experimentation." A medical student from the university [5] commented that the method of trial and error was too hard a way to learn. And an educator from Antigua [6] warned the young people present to use their reason, to try new things, but to control their impulses and mistrust their experience, and to draw on the experience of older people.

However, a Virgin Islands high school student [7] responded by maintaining that a young person must have enough self-confidence to be able to say to himself, "I can be right, he can be wrong."

Time and again in the discussion groups young people expressed a sense of dissatisfaction with their elders in such remarks as: "Our parents don't trust us," or "Young people look to adults for direction, but adults seem to need direction."

Cultural Influences

Thus, much of what was said would apply in New York, New Orleans, or Peoria, Ill. But inevitably, just as the observer was beginning to feel that he was back at the 1960 White House Conference on Children and Youth, the special circumstances of being an adolescent in the Caribbean would emerge. It became clear that while these were similar in most of the islands, they were not exactly the same. For example, a psychiatrist from Aruba [8] reported that in his island the entire process of adolescent development is shorter than in most Western countries; but in Haiti, according to a psychologist,[9] the parents tend to prolong adolescence by keeping young persons dependent upon them until they are nearly 20.

In all the islands, it became apparent, young people are faced with conflicts between old layers of cultures within the islands as well as between the old and the new. These Caribbean islands in the course of history have been passed from nation to nation, with the result that in many of them a variety of European cultures have been imposed upon the descendents of the people brought from Africa. For example, a social worker reported [10] that among the middle classes in Curaçao both the Spanish strictness with the young and the more lenient Dutch attitudes have persisted, to the confusion of young people and their parents alike. In the lower economic groups, the woman is usually too overburdened to have time and energy for supervision of the young, she added.

There were a few who maintained that the great majority of Caribbeans of African descent had never truly assimilated the overlays of European culture. The Aruban psychiatrist [8] said that the European arts, philosophy, and religion have penetrated very little because they do not give enough emotional satisfaction to the people. The young Caribbean, he said, learning one thing at home and another at school, develops a kind of "double super-ego," the two parts living independently, unintegrated and often disputing each other. He saw signs, however, in the new surge for independence, of a reorientation of the adolescent to new norms and new values not requiring the loss of the young person's own nature.

The poignancy for young people of the conflict in culture values came out clearly in another psychiatrist's [11] analysis of attitudes in the Virgin Islands toward sex. The adolescent of the lower classes there, he said, because of "historical and environmental influences" has been rather removed from the inhibitions on sexuality imposed by Western society. Unmarried girls gladly fulfill the function of motherhood without being stigmatized, he maintained. There is a pride, among both sexes, in producing progeny, he said, but little tenderness between sex partners, though the girl longs for marriage to achieve status. While these young people are beginning to doubt past values, he added, they are suspicious of the new ones to which they are exposed. Saying that psychiatry has no ready answer for them other than to help them reach their own "self-

rearrangement of meaning," he suggested that an intensive study of the psychodynamics of "fathering" be undertaken, and that the findings of this be conveyed to adolescents.

Fathering

The matriarchal—often fatherless—family received much attention at the conference. Evidence was presented indicating that in all the islands, except Puerto Rico, this type of family is common in the lower economic groups, with the male being regarded as hardly more than an impregnator and an unreliable means of support. Because fathers often wander off, whether from a marriage, a consensual union, or a casual affair, many young women are left with a number of children to support and in order to have some help in this, take up with another man.

Whether the reasons for this go back, as the Virgin Islands psychiatrist [11] suggested, to customs enforced in slavery days or brought over from Africa, or, as a Jamaican anthropologist [12] maintained, lie chiefly in the inability of men to find steady employment, the result is often a passing around of children to grandmothers and other relatives and a lack of any sustained male adult model in the family.

While the question was raised, with superficial levity, as to whether fathers were really needed, since so many people in the West Indies have grown up without them—"and still we are creating a new nation"—the psychiatrist from Trinidad [13] who raised it provided an earnest answer, that children need fathers in adolescence more than at any other time. However, he too suggested the need for more studies on the effects of "paternal deprivation."

Repeatedly one heard references to persons who served or might serve as substitute fathers—older brothers, the mother's father or brother, a godparent, the mother herself, a community representative, such as a teacher.

The importance of the father figure to the child seemed to be generally accepted with a kind of pessimism about the possibilities of achieving this for every Caribbean child. One discussion group reported as a point of consensus, "Half a father is better than none."

Racialism

A kind of bombshell was dropped in the inaugural session of the conference when the featured speaker, a social psychologist from the United States,[14] devoted a large portion of his speech to a discussion of racial discrimination and its effect on mental health—a bombshell at least to an observer from a land where discrimination is much more evident than in the West Indies. But the purpose of the emphasis became clearer as the week went on.

While racial segregation is generally absent, persons living in the area pointed out, an insidious kind of discrimination based on color and shade, practiced even within families, operates against the opportunities of some young people to achieve educational opportunities, suitable employment, and social status. An American anthropologist [15] noted, however, that, as the West Indies moved toward independence, achievement, more than color, was becoming the indicator of status.

The inaugural speaker [14] also referred to "racialism in reverse," a growing hatred of whites observable in many countries today, and warned that "racialism" is bad mental health no matter who is practicing it. This point, however, was challenged by a West Indian sociologist,[16] who said that as oppressed groups move into different positions they can be expected to take racist attitudes, "but these should pass eventually except in sick personalities."

The Changing Scene

This shift in positions of discriminator and discriminatee was but one of many changes in the Caribbean mentioned. Most talked about was the political move toward self-determination—especially in the islands of the West Indian Federation—and its personal counterpart in the urge of masses of young people for self-realization. Others were the rapid industrialization of Puerto Rico, the growth of tourism as an industry, the flocking of young people from the rural areas to the cities, and the mass emigration of West Indians to Great Britain and of Puerto Ricans to the United States—all factors in the rising expectations of the masses as well as in family disruption and conflict between the generations. In Barbados, it was pointed out, the population pressure is so great that the government is paying young people to emigrate to England.

There was some decrying of standards "brought from abroad" [16] and of reliance on "Yankee ideas," [17] as well as expressions of fear that tourism would bring segregation patterns and a spread of servile attitudes.

How misleading the transplanting of foreign developments can be was demonstrated by a psychologist from Haiti [9] in telling of the difficulties of measuring the intelligence of illiterate Haitian children

Rita Varela, youth delegate of Puerto Rico, speaks to the conference on adolescents in the changing Caribbean. The others are, left to right: Dr. Guy Benoit, psychiatrist, Guadeloupe; Beverly Moyston, social worker, Jamaica; Eldra Shulterbrandt, psychologist, U.S. Virgin Islands.

with tests developed in Europe and North America. These children, he said, often confuse the psychologist with a voodoo priest, and have strong superstitions which predispose them to answering some questions in a manner that may seem on the surface illogical. He suggested the development of clinical instruments more adapted to the culture.

From a broader view, a West Indian sociologist [16] urged the islands to take more "local initiative" in solving their economic problems and labeled Puerto Rico's 20-year-old industrialization program, Operation Bootstrap, an "Operation Retreat" because it depended on capital from the United States.

Operation Bootstrap, however, was defended by spokesmen from Puerto Rico though they did not ignore the human problems that industrialization brings. A Puerto Rican psychologist [18] said that the program represented retreat only from illness, poverty, and "outmoded nationalism." However, he pointed to a loss of communal cohesion in new housing developments, a widespread relaxing of parental standards, and a prevalence of personal anxiety as evidence that organization for community purpose must be a part of socioeconomic planning.

The changing family structure in Puerto Rico was referred to many times. Operation Bootstrap in the early years, it was reported, had emphasized light industries where the skills of women were needed more than of men. This has meant that in many families the woman has become the chief or only breadwinner, thus undermining the authority of the father, traditionally strong in Puerto Rico. In some families the father emigrates to the United States for as long as 5 months a year to work in agriculture.

The result of these changes, according to a Puerto Rican psychiatrist,[19] is widespread family distegration, increased juvenile delinquency—a 77-percent increase of court cases over the past 3 years—and an uncounted number of emotionally disturbed children and adolescents. He proposed the utilization of psychiatric centers to train personnel from all professions in the techniques of helping anxious people.

While considerable concern was expressed in discussion groups throughout the week over ways of instilling moral standards, only a few specific reports on juvenile delinquency were presented during the conference, and what figures were given could not be regarded as comparable from island to island. Nothing was presented from the other islands, however, to equal the rise in court cases reported from Puerto Rico.

A psychiatrist from Martinique [20] reported a higher incidence of thefts and "fugue states" among young people in that island than in France, putting the blame on a "passive spirit of unconcern" caused by the child's understanding very early in life that his efforts to rise from poverty will be in vain. A Jamaican social worker [21] maintained that overcrowding had a lot to do with the property and sex offenses of children who come before the courts in Jamaica. A medical officer for an oil company in Trinidad [22] reported more trouble from the "bored" children of the management staff than from a group of less privileged youngsters employed in the company's apprenticeship program.

Hopes and Fears

All during the conference one heard of the great aspirations of the young, reflected especially in what sounded almost like a mad scramble for education.

"I'm going to be a psychiatrist if it takes me until I'm 90," said a Jamaican high-school girl. And a high-school boy from the Virgin Islands explained the educational steps he expected to take to become a nuclear physicist.

These were middle-class youngsters, but high educational aspirations were also reported as held by

thousands of young people of the lower socioeconomic groups throughout the Caribbean and especially in the islands of the West Indian Federation. Educators from these islands all told the same story of young people aspiring to a university education regardless of ability.

"Education is the young person's passport out of the lower social structure," said an Antiguan educator.[6] A welfare worker for the Jamaican sugar industry [23] said that young people in rural areas did not want to stay to be caneworkers, even when the company built new housing. A survey reported from Trinidad found that only 3 in 1,200 youngsters wanted to go into agriculture.

What some of the young are up against in achieving their education was indicated in a report of a study made in Antigua.[6] In answer to a query about the main problems affecting the lives of secondary school pupils, teachers and pupils alike frequently mentioned: (1) worry about a future job; (2) lack of light and space for study at home; (3) poor school plant; (4) shortage of recreational facilities; (5) poverty ; (6) and lack of time for study at home.

The realities behind item 2 were made clear by a single sentence in a report of one discussion group: "Ideally a home should have two rooms, so that the children don't have to witness their parents' sexual intimacies."

That the pressure to learn may be taking a toll in mental health was indicated by a Jamaican psychiatrist [24] who reported that of 162 persons seen in a psychiatric clinic for adolescents during the past 5 years, 71 were suffering from "anxieties due to educational distress." A medical student [5] from the university, in reporting on a group of 50 young people he had worked with in a housing project (with the "ideal" two rooms to a family—sometimes of 7 or 8 people), gave a picture of the hopelessness of those who do not make the educational grade. Dissatisfaction with their jobs and feelings of helplessness were characteristic of these young people, all of whom had had to leave school by the age of 16.

There was obvious consternation on the part of a great many adults—particularly educators—at the height of the ambitions of the young. "They all want to be doctors" was a frequent comment. "Nobody wants to work with his hands," said an educator from Jamaica.[25] "We must teach young people the dignity of hard labor." Efforts were reported to lift the status of vocational schools among young people by calling them technical high schools and including them in sports competitions with the academic schools. But a great deal of worry was expressed in group discussions lest many more persons become educated to expect white-collar jobs than the job market could absorb.

Reporting on a study of career aspirations of secondary school students in Trinidad, an American anthropologist [15] pointed out that in government-supported schools, the majority of both boys and girls aspire to occupations requiring a university degree. She also reported "a positive relationship between high personal ambition and desire to help one's community" in all but the white students.

Warning against the dangers to society of allowing such widespread ambition to be frustrated, she suggested that in addition to guiding young people into the technical professions needed for economic development, the islands create a youth corps, similar to the U.S. Peace Corps, to work in community service at home. Trinidad, she said, has already used the services of young people in the rehabilitation of a slum area.

In a similar vein a Chicago psychiatrist [2] suggested that youth in the Caribbean is needed to carry on the task of creating a better society.

Suggested Action

What did it all add up to? From the beginning this was an action-conscious conference, each of the 11 discussion groups being charged with drawing up recommendations for promoting the mental health of young people in the islands. These were summarized at the final plenary session, where, in addition, a member of each discussion group presented a brief report of its priority recommendations.

Some of the groups included in their reports observations that many of the problems confronting young people in the Caribbean today stem from the widespread poverty and unemployment. One group "implored the governments" of the islands to proceed with economic development, but warned that economic advance is inevitably accompanied by social problems.

Most of the priorities stressed some form of family life education. They included:

- The stimulation of discussion groups between adolescents and adults.

- Systematic research in the various islands to determine the nature of young people's problems, with the results being made available to families.

- A community educational program, directed at both adolescents and adults.

Other priorities included vocational guidance in the schools, apprenticeship programs, improvement and spread of technical schools, sex education in the schools, and efforts to bring school teachers a greater understanding of mental health and the nature of adolescence.

In the total recommendations, improvements in education, vocational guidance, and family life education received strongest emphasis. Youth discussion groups and recreational programs were also emphasized. Four groups suggested youth corps.

There were a number of indications that these recommendations would not just gather dust. First, there were such remarks as "when I go home I'm going to start a youth discussion group in my neighborhood," or "I'm going to try to get some youth volunteers to work in my boy's club." Then there were the accomplishments since 1959 reported by the nine mental health associations represented at the conference—those of Aruba, Barbados, Curaçao, Haiti, Jamaica, Martinique, Puerto Rico, Trinidad, and the U.S. Virgin Islands—and the report that Guadeloupe has an association in the making.

Among the great variety of achievements these associations reported were: a survey to determine vocational guidance needs (Aruba); establishment of a center for delinquent boys (Haiti); organization of six local mental health clinics (Martinique); holding community forums to discuss healthy ways of living (Puerto Rico); successful efforts to have the mental health law revised (Trinidad); carrying on a newspaper column on children (U.S. Virgin Islands); and, of course, playing host to the Third Caribbean Conference for Mental Health (Jamaica).

Youth at the conference, scattered in the 11 discussion groups, spoke up chiefly as individuals, but the collective voice of youth was heard at the beginning and at the end. At the first morning session a Puerto Rican high school girl [26] reported on the views of 300 high school students "of poor and middle-class families" polled by the youth committee of the Children's Commission of Puerto Rico. Among the top needs these students had identified were: enlargement of scholarship programs for "high-level" studies; more vocational schools; and guidance programs for high-school students. But they had also asked for programs of family life education and counseling for heads of families.

The final words of the conference came from a youth participant reading a statement for the entire youth group. It ended, ". . . if, as we grow, more and more responsibility is gradually shifted to us, surely we will soon be able to decide even major matters for ourselves."

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[1] H. C. Rumke, M.D., professor of child psychiatry, University of Utrecht, The Netherlands.

[2] Bruno Bettelheim, M.D., professor of psychiatry, University of Chicago.

[3] Rev. Lewis Davidson, Principal, Knox College, Jamaica.

[4] C. R. Ottley, Director of Community Development, Trinidad.

[5] W. R. Wong, medical student, University College of the West Indies, Jamaica.

[6] Christopher O'Mard, Assistant Inspector of Schools, St. John's, Antigua.

[7] Evans Harrigan, student, St. Thomas, Virgin Islands.

[8] F. E. A. Blom, M.D., psychiatrist, Aruba.

[9] Emerson Douyon, Director, Centre d'Orientation, Port-au-Prince, Haiti.

[10] Anna C. Winkel, social worker, Curaçao.

[11] J. Herbert Fill, Clinical Director, Bureau of Mental Health, St. Thomas, Virgin Islands.

[12] Edith Clarke, anthropologist, Jamaica.

[13] Michael Beaubrun, psychiatrist, St. Ann's Mental Hospital, Trinidad.

[14] Otto Klineberg, professor of psychology, Columbia University, New York.

[15] Vera Rubin, Director, Research Institute for the Study of Man, New York.

[16] Lloyd Braithwaite, senior lecturer in sociology, University College of the West Indies, Jamaica.

[17] M. G. Smith, senior lecturer in sociology, University College of the West Indies, Jamaica.

[18] E. Sanchez-Hidalgo, professor of psychology, University of Puerto Rico.

[19] E. D. Maldonado Sierra, Executive Director, Puerto Rico Institute of Psychiatry.

[20] Michel Ribstein, psychiatrist, Colson Mental Hospital, Martinique.

[21] Winnie Hewitt, Chief Children's Officer, Child Care and Protection Division, Ministry of Housing and Social Welfare, Jamaica.

[22] Reynold C. Dolly, M.D., senior medical officer, Texaco Trinidad, Inc., Pointe-a-Pierre, Trinidad.

[23] Ivy Lewis, Sugar Industry Labour Welfare Board, Jamaica.

[24] K. C. Royes, M.D., psychiatrist, Bellevue Hospital, Jamaica.

[25] Reginald E. K. Philips, Deputy Chief Probation Officer, Jamaica.

[26] Rita Varela, student, Santurce, P.R.

A mental health service experiments in . . .

FAMILY STUDY AND TREATMENT

NATHAN W. ACKERMAN, M.D.
Director, Family Mental Health Clinic, Jewish Family Service, New York

BY TRADITION, the study of human adaptation and associated conditions of health and illness gravitates to one of two extremes; either to the processes of individual personality or to those of society. Accordingly, parallel advances have been made in individual psychology and in the science of society and culture. Paradoxically, however, the study of human adaptation in the area intermediate between the individual and society has thus far suffered a serious neglect.

The family as an intermediate system of behavior offers a unique challenge for study. The long lag in the systematic investigation of the family phenomenon as the unit of experience, of health, and of illness is striking when one recognizes that the family is the critical link between the internal forces of personality and the wider forces of culture. To be sure, the family has been extensively studied as an economic, social, and cultural entity. But the family as a live, biosocial phenomenon with definable psychodynamic properties has not been the theme of scientific research until the last few years.

The reasons for this lag are not altogether clear. One may consider several possible explanations. There is the long tradition of the privacy, the sanctity, the inviolability of the inner life of the family, and the corresponding resistance to intrusion from the outside. This makes the systematic study of the personal, intimate aspects of day-by-day family living difficult. On the other hand, the weakening of the family bond that has resulted from the industrial revolution and from the impact of the protestant ethic and of the competitive pattern of our culture has had the effect of heightening the significance of the individual and of reducing the importance of the family. Thus, the dominant sentiment has become "each man for himself."

Whatever the cause, the scientific examination of the emotional processes of family life has long been delayed. In mental health work over a period of many years, this has had several manifestations: in child psychiatry, a curious trend toward dichotomization of child and family; in psychoanalysis and psychotherapy, an emotional divorce of the adult patient from his family during treatment; in group psychotherapy, a concentration on intrapsychic distortion and neglect of group dynamics.

Looking backwards over some 30 years of child psychiatry, one can detect extraordinary progress in the scientific study of the personality of the child, but no equivalent advance in the scientific examination of the child's family environment. In fact, it is possible to trace the persistent difficulty in achieving satisfactory standards of diagnosis and treatment of psychiatric disorders in children partly to the failure to find ways to diagnose and treat families as families. Guidance programs have been centered on the child as an individual. The child's response to environment has been mainly reduced to an issue of the influence of maternal attitudes, these being appraised as an external agent acting upon the child. The path of study has usually moved from the child at the center to family environment at the periphery. The conflicts, symptoms, and emotional disabilities of the child have not been adequately defined in terms of the child's total personality nor in the frame of his adaptation to his family roles.

As a consequence of this conceptual separation of child personality from family environment, the relations between the child as an individual and the child as part of the family have not been adequately clarified. Only in recent years has the mother-child relationship been understood as a circular process, child affecting mother as well as mother affecting child. Again, only recently has mothering behavior been systematically related to father behavior, and to the psychodynamics of the family as a whole.

During the past 30 years child guidance procedures have crystallized into a tradition of separate

diagnosis and separate treatment for child and mother. The direct psychotherapy of the child has been given priority, the treatment of the inappropriate attitudes in the mother being regarded as auxiliary. The evaluation of parent and family has been intuitive, piecemeal, hit and miss. Generally, the child patient has been assigned to the most skilled member of the guidance team, the psychiatrist and the mother, to a social worker. Often the father has been "the forgotten man."

Thus, the child has been treated as all-important, while the family has been regarded as of external and tangential significance. Frequently, the child has been viewed as good, the mother as bad. The child's therapist has taken the side of the child against mother and family. In effect, the therapist has assumed the role of lifesaver, his mission to rescue the exposed, vulnerable child. In this emotional setting, the parent has been visualized as destroyer of the child. Now and then, the child therapist is facetiously called a "mother killer."

The value distortion in this child guidance procedure is clear. It is obviously wrong to pit the child against parents and family. The emotional needs of the parents require the same respect as those of the child. Unless the disturbances of parents and family are examined and understood with the same sympathy and scientific rigor as the emotional life of the child, the child's problem in its larger aspects can never be solved.

Some Clinical Observations

The study and treatment of emotional disorders in children need to be accompanied by a parallel program of study and treatment of the family phenomenon. The importance of this is reinforced by a series of interrelated clinical observations:

1. The emergence of a psychiatric disorder with symptoms in a child patient is regularly preceded by family conflict.

There is a definable relation between the conflicts of the child and the conflicts of the family group. The failure of emotional development in the child is a symptom of failure of the emotional development of the family.

2. If the child is treated and the disorder of his family ignored, the child again falls ill.

3. If the child gets better, other members of the family may either get better or they may get worse.

If the child becomes less anxious, less torn by inner conflicts, and better integrated, the mother and other members of the family may also show a reduction of anxiety and conflict. On the other hand, if the emotional needs of other family members compete with the needs of the child as the primary patient, as the child improves the others may get worse. This is often clearly reflected in the spontaneous remarks of disturbed children in therapeutic sessions. They sometimes exclaim: "Why don't you treat my mother? She's more nervous than I. She needs you more than I do." Or the child may make similar comments with respect to his father or his siblings.

In some cases even when child and mother both improve, the father gets worse.

4. Conflict and anxiety among other family members may block progress in the child's therapy.

This is especially true when the child is the emotional pawn in a conflict between the two parents. If a change in the child's behavior alters the preexisting emotional balance between the two parents, the defensive response of the parents may retard the child's progress.

5. Over a stretch of time, the intervention of professional influence in family affairs, whether by a psychiatrist, social worker, teacher, pediatrician, or nurse, tends to modify the effect of preexisting family relationships and so rebounds to modify the behavior of the child.

6. A disturbed child is often not cured in a single course of psychotherapy regardless of the intensity of treatment.

At a given stage of a child's development, the child may be able successfully to confront certain conflicts and yet at a later stage may not be prepared to face new kinds of life problems. The result may be a new disturbance, regardless of previous therapy. This is more likely to be the case where family disorder persists.

7. When one is able to involve the whole family in a comprehensive program, one is better able to join the goals of treatment and of prevention.

This is especially relevant for the prevention of emotional disorder in the patient's younger siblings.

8. In our country there has been a long tradition of respect for the importance of environmental factors—especially the climate of family relations—as influences on child personality. What is true of child personality is also true of the mechanisms of adult personality, though to a somewhat lesser degree. Even if one takes fully into account the qualitative differences between child and adult personality, the fact remains that the operations of adult personality also depend on the social environment, though this is expressed in a different way.

To be sure, the contrast between child and adult personality is considerable. The child is a growing being; his personality is in the formative stage; there is great fluidity and change; the impact of the environment upon his emotional life is apt to be immediate. The personality of the adult is more organized, more differentiated, more static. Yet these are differences in degree rather than in kind. The adult, as well as the child, is profoundly affected by family environment. We need to know more about the interdependent and interpenetrating effects of the ongoing relations of a person with his family group, at all stages of the life cycle.

Differences at Home

This principle is affirmed in clinical evaluation of psychiatric patients. In the case of child patients, it is unwise to depend exclusively on observations of the child in office examinations. It is extremely helpful to supplement these with observations of the child at home with his family group. Frequently one observes that the same child will behave differently in these different settings, and with different members of his family.

Only recently I had a striking experience of this sort. In a family group containing two daughters, one age 15, the other 10, both children were seriously disturbed. The older daughter was withdrawn, shy, had few friends, and was especially wary of boys. She absorbed all of her energies in study and had a single-tracked ambition to be a doctor. The younger daughter was infantile, restless, overactive, impetuous, and difficult to control. She expressed emotion more with gesture and body movement than through the use of words. She was overaggressive, provocative, intrusive, unsure of herself, and fearful.

In the background there was a chronic marital problem. The father at 62 was an old man; the mother at 36 years was a very young woman. The father was a homebody, who complained bitterly of the mother's neglect of the children, of her restless urge to gad about with her young friends. The mother was an immature, hysterical woman who behaved like a runaway child. The two were sexually maladjusted; the mother had lovers.

In the office interview, what emerged conspicuously from the children's behavior was their sick side. What emerged in a home visit was strikingly different. Elements of strength and health could be observed in these children in their normal habitat with both parents which could not be seen in a formal office interview at all. For example, in the home visit, the girls showed more security and confidence. Their behavior was better balanced, more appropriate, freer, more spontaneous, and at the same time revealed more appreciation of the individual differences between them. They revealed more expressively their individual interests and aspirations. In the home atmosphere, they were responding to the more familiar evidences of the parents' joint concern for their welfare.

Similarly, one can learn more about the total behavior of an emotionally troubled adult by interviewing him with his family or visiting with him in his own home in addition to seeing him alone in the clinic. What one can observe exclusively in the process of psychiatric examination in a clinician's office is often not enough and sometimes misleading. For this reason, for many years, I have made it a practice to parallel the psychiatric diagnosis of the patient with a family diagnosis.[1]

The family approach to mental health problems is an experiment true to nature. It enables the therapist to examine within the dynamics of the family unit how mental health is promoted, how breakdown may be prevented, how illness may be cured. He can explore those familial processes that are related to breakdown and also other familial processes that are related to healing, to spontaneous cure. He can begin to see how the natural events of family life either heal or fail to heal disturbance in its individual members.

This approach is now being used with emotionally disturbed children at the Family Mental Health Clinic in New York. At this clinic, under the auspices of the Jewish Family Service, diagnosis and treatment are tied into a broad research program of the study of family processes as they relate to mental illness. Here the study of family process had led to the capturing on educational film the true-to-life behavior of psychiatric patients adapting to their natural day-by-day environment, the family.

Specifically, in these studies we are trying to learn:

1. How to describe the emotional and social life of the family group as a basis for diagnosing the psychosocial functioning and mental health potential of the family unit.

2. How to compare and contrast family groups, thus making a way for a family typology with respect to mental health functioning.

3. How to correlate family dynamics and individual dynamics with respect to mental health.

4. How to develop a psychotherapy of the family group.

5. How to find ways to join the methods of psychotherapy with those of social treatment and family life education to apply them in an integrated program for the promotion of mental health and the prevention of mental illness.

The complex nature of this undertaking may raise the question: "Can it be done?" The answer is that it is being done. We have been working on all phases of this program at the Family Mental Health Clinic with a conviction of real progress. While indeed complex and difficult, it is not any more so than attacking the problems of mental health through isolated individuals. In fact it may in the end prove easier because the therapist's intervention comes at a more natural time—when the family members are interacting with one another. It does not have the effect of distorting emotional and mental experience by isolating the patient from his environment.

In fact, when an individual patient is treated away from his family he brings the images of his interactional experience with his family group into his therapeutic sessions anyway. The therapist is forced to deal with these images of other family members, but does so in symbolic form. The comprehensive attack on the problem provided by the family approach enables the therapist to use actual face-to-face contacts with members of the family rather than to rely only on vague symbolic relations with them.

Foci of Study

In studying a family, we pay particular attention to the following:

1. The organization and balance of family functions.

2. The process by which roles within the family become complementary.

3. The patterns of conflict and control of conflict. This includes consideration of trends toward scapegoating of an individual member and delegation of another member to fulfill the role of family healer.

4. The capacity for change and growth; that is, for the achievement of new levels of family role complementarity. This capacity determines the potential levels of maturation of the family as family, as well as the emotional growth of its members.

5. The representations of family identity and the corresponding value orientations.

6. The degree of correlation between the health of the family as a whole and the health of its individual members.

In order to carry out its research goals, the clinic limits the caseload to some 50 families. The professional staff is composed of four groups: psychiatrists, social workers, social scientists, and psychologists. Of these, the psychiatrists and social workers carry the clinical responsibilities of evaluating and treating whole families. Within this larger group, a smaller research team of a multidiscipline type carries on a series of specific interrelated investigations in family dynamics as this pertains to emotional illness and health.

In the carrying out of health services to these families, we do not follow the traditional pattern of clinical assignments for psychiatrists and social workers. Assuming prior training in the methods of family diagnosis and treatment, both members of the psychiatric and social casework profession undertake therapeutic duties. As a matter of principle, when the family has a psychotic member, such a case is generally assigned to a psychiatrist. Otherwise, where the causative factors are mainly social, we try to fit the needs of a given family to the talents of a particular professional staff member rather than obeying any stereotyped standard for the specialized use of the professional categories.

The motion-picture studies on family interview process are made in the first instance for purposes of specific investigations, but also serve as a unique instrument for training members of the behavioral sciences in the principles of family diagnosis and therapy. The families who are thus filmed sign a release which permits us to make full professional use of these films, but do not permit us to exhibit these films to lay audiences. Not only are the families fully aware of being filmed during interview, but they are also informed that the entire staff of the clinic is observing the interview from behind a one-way-vision window. Directly following the filmed interview, there is a clinical seminar in which the emotional events of the interview are evaluated.

In our experience, families understand and appreciate the value of the filming process, both for purposes of study and for reaching greater clarity and precision in diagnostic judgment and in the psychotherapy of the whole family. Generally speaking, beyond the first few minutes, just as soon as the emotional interchange is deeply felt by the family members, they lose all self-consciousness and are not in any sense "on their good behavior." The prevailing patterns of emotional interaction among the family members and between them and the therapist can thus be viewed as characteristic of the given family and reliable for diagnosis and treatment.

I am often asked whether the family approach

competes with the individual approach to therapy. The answer is: "No. It is complementary." The individual forms of psychotherapy are useful in attacking entrenched forms of psychiatric disorder with organized symptoms such as phobias and obsessions. Since intervention in family interactions can affect the ongoing relations of individual and family group, it influences the course of the illness and the patient's response to individual therapy. These ongoing relations in the final analysis govern the balance of forces that predestine relapse or cure.

Complementary Techniques

Effective intervention in family interactions requires the appropriate focusing of therapeutic influence to certain pathogenic foci, such as destructive attitudes or unrealistic expectations, within the family group. Regardless of the particular time at which the clinician intervenes, he can trace within the family processes those clusters of pathogenic conflict from the past which continue to influence the disturbance of the primary patient.

The foci of disturbance within the family group that originally contributed to one member's psychiatric illness continue to assert themselves in the here-and-now aspect of family interaction, though they may in time change their mode of expression, since the emotional organization of family life changes over a period of time. Therefore, intervention in family interaction requires appropriate timing and staging. It is, however, possible to design a parallel program of family psychotherapy and individual psychotherapy for those family members whose psychiatric condition may require it.

No technique of psychotherapy which is presently known is total in its effect. Each exerts a partial and selective influence on some components of the disturbance, but not on all. Psychoanalytic therapy exerts a selective influence on the depth phenomena of personality. Group psychotherapy of the usual type exerts a selective influence on the character, attitudes, and preferred social modes of the patient, in other words, on the role adaptation of the personality. Family psychotherapy in turn has a distinctive quality. It holds the unique potential of selectively influencing and eliminating specific components of disturbance in family interaction.

The family approach to psychotherapy holds far-reaching implications for a changing orientation to mental health services, especially for the development of new health programs for child and family. The recognition of these principles led to the formation of the Family Institute in May 1960 as a nonprofit national organization representative of psychiatry, psychology, medicine, social work, and related professions, with the twin goals of preventing family disorder and supporting the development of effective health in family living. The institute, with headquarters in New York, will carry out the following functions:

1. Develop facilities for diagnosing and treating emotional disturbance through families; that is, evaluating and treating conflicts and symptomatic disabilities in individuals through therapeutic intervention in the emotional life of the whole family.
2. Develop specific research studies relating to the processes of breakdown and illness within the family as a whole and to work toward the restoration of family mental health.
3. Train psychiatrists, psychologists, physicians, and social workers in the principles of family diagnosis and family treatment.
4. Promote education in the principles of sound family living.
5. Prepare, publish, and distribute educational materials for members of the various professions working with disturbed families. This includes studies in film of the methods of family treatment.

The significance of the family approach to mental health problems derives from a number of considerations. Such an approach provides us with the possibility of specifying and amplifying our present incomplete knowledge of the interconnections between individual dynamics, family dynamics, role adaptation, and mental health. It can trace the circular pathways of emotional interchange between individual and family, thus throwing light on the role of family life in the precipitation of illness, in influencing its course, in the response to therapy, and in the probability of recovery or relapse. It can illuminate the phenomenon of secondary emotional gain in illness. It can provide a laboratory for the further exploration of the unsolved problems of homeostasis of behavior and the related question of the balance of emotional forces between illness and health. It may add new knowledge to the question of the relations between identity, value orientation, and mental health.

[1] Ackerman, Nathan W.: The psychodynamics of family life. Basic Books, New York, 1958.

GROUP EDUCATION FOR PARENTS OF THE HANDICAPPED

ALINE B. AUERBACH

Director, Department of Parent Group Education
Child Study Association of America

THROUGHOUT the country there is a growing interest in group programs for parents of handicapped children, an interest which is not surprising since group programs for parents of well children have become part of many American communities. This interest is being picked up by the increasing number of parents' organizations that have been formed around disabilities to acquaint the public with the nature of the handicap, to raise funds for research, and to push for more and better services for their children. Quite naturally the major attention of these organizations has from their inception been concentrated on the children.

But individual parents have been reaching out for more—a kind of knowledge and help that they have hardly defined for themselves. Their desire for help has been revealed in informal discussions around the edges of business meetings, sometimes even taking the center of the stage and interfering with the main purpose of the meeting.

Thus many agencies serving the handicapped have come to see the need for two different types of parents' programs—one with focus on community action to improve services for all children having the specific handicap with which they were concerned, and the other with focus on helping the parents in their daily living with their children. Where separate programs could not be set up, parents' meetings have been more effective when the two goals have been identified and handled separately.

Agencies providing services for handicapped children have often held informational meetings for parents in the form of lectures by the professional staff, describing the disability and the therapeutic, educational, and other services available. While these meetings have been useful, the persons programing them have often felt that more should be offered, through casework services or another kind of group program or both, to meet the needs of the parents as they themselves see them.

However, in attempting to develop more meaningful group programs, agencies have often been limited by the lack of group leaders. Even well-trained social workers and psychologists often feel unprepared to conduct group programs of this nature. Therefore, professional persons of various types have been turning to the Child Study Association of America for preparation for this work.

Parent Group Education

Within the past 10 years the association has given training in parent group education to selected social workers, psychologists, educators from various settings, and public health and hospital nurses. This training has concentrated on the use of group discussion geared to the needs of the parents in the group and developed from their expressed concerns in a flexible procedure, rather than to a predetermined curriculum.

In parent group education the goal of the leader is to help group members explore all aspects of the situation in which they find themselves with their children, to gain greater knowledge and understanding of their children's physical and emotional de-

velopment, of their own roles as parents, and of the complexity of parent-child relations. They do this through the exchange of ideas and experiences within the group interplay, looking at both facts and feelings—theirs and their children's. Sharing their reactions with others under skillful leadership seems to free the parents to move on to new attitudes and new behavior, or to have greater confidence in what they are already doing.

The goals and techniques of group education are different from those of group therapy. The group education leader does not focus on the pathology of the members, or probe into the unconscious. Although he must take into account the unconscious factors that influence behavior, he deliberately directs group thinking toward aspects of ego functioning, in order to develop ego strengths.

Some Questions

In the early programs of training leaders for parent group education, the focus was on parents of normal children. As the interest mounted in establishing programs for parents of the handicapped the association was asked to set up a special training program for social workers who would be working with families of children with disabilities.

Implied in this request were a number of important issues:

- Is the method of group education developed for parents of normal children applicable to groups of parents of children with such different problems?
- How similar and how different are the concerns of parents of chronically ill or disabled children from those of parents of well children who present merely the normal range of developmental problems as they grow up?
- Can group education be expected to ease the extraordinary burdens on parents of the handicapped and help them to handle their lives and those of all their children, including the nonhandicapped, with greater ease and satisfaction for all?
- Do adaptations in techniques have to be made in working with parents of the handicapped to achieve the basic goals of group education for all parents, and, if so, what is their nature?

The association had already recognized that these questions needed further exploration in practice as well as in theory. It had, therefore, set up experimental groups, under the sponsorship of various health and rehabilitation agencies, for parents of children with muscular dystrophy, cerebral palsy, mental retardation, and two congenital blood diseases. The groups were conducted by association staff members who had familiarized themselves with the nature of these specific disabilities and the special problems they presented for parents as well as children. A social worker from the cooperating agency usually participated as a resource person. The association also had had experience in adapting the basic approaches of parent group education in programs to train public health and maternity nurses to lead groups of expectant parents.[1]

Encouraged by these experiences, the association, with a foundation grant, set up a demonstration program to train social workers in parent group education for parents of handicapped children. The hope was that the experience of the social workers in conducting parent discussion groups in their own agencies would throw more light on the foregoing questions. The association also looked to the project to explore some questions regarding the recruitment and readiness of parents for this type of experience, and the effect on the groups, of their makeup, in relation to degree of homogeneity in the parents' backgrounds, and in the prognosis and severity of their children's conditions.

A New Project

The project was initiated with a selected group of social workers from the staffs of hospital social service departments and health and rehabilitation agencies in New York City, and from the New York City Health Department. These agencies were interested in developing group educational services for parents and had experienced social workers who were familiar with the disability of the children with whose parents they would be working.

The program included 15 weekly sessions devoted to a review of the principles of child growth and development and the many distortions created by various disabilities; discussion of the parental concerns common to all parents as they are colored by the nature, prognosis, and special meaning to parents of their children's handicaps; and presentation of the principles, goals, and techniques of parent group education as applied to the needs of parents of handicapped children. These sessions, conducted by guest experts from the fields of medicine and rehabilitation, psychiatry, psychology, education, sociology, and cultural anthropology have been supplemented by seminars led by association staff members who also supervised the participants as they conducted parent groups in their own agencies, in health and rehabilitation organizations or in special clinics, recreation

and workshop centers, hospitals, and public schools. Each parent group was concerned with a specific disability—orthopedic handicaps, cerebral palsy, mental retardation, or cleft palate—except for two groups of parents whose children's disabilities were not all the same.

What Emerges?

What takes place in such groups? Since the subject matter is not preplanned but is developed from the interests of the members, there can be no general answer. Parent group education, like casework, focuses on the parents and their concerns, meeting them "where they are." So the discussion may start at almost any point.

Often the early meetings of a series are taken up with practical problems of routine care as compounded by the child's disability. Parents of young children who are mentally retarded or cerebral palsied or both bring up their struggles with the whole range of developmental tasks they are trying to help their children to learn—feeding, toileting, dressing and undressing, climbing stairs. Parents of severely orthopedically handicapped teenagers may talk about the constant chore of getting their young people to school, a recreation center, or just outside the house.

Everyday problems continue to appear in many forms throughout the series of meetings, and in these discussions the parents gain a great deal from the experiences of others. Even though the degree to which their children are disabled may vary enormously, the ingenious procedures some parents have worked out often open up new ideas relevant to many different situations, which the parents often adapt to the needs of their own children. Sometimes a parent has tried a new way of bathing a severely crippled child, for example, or a different approach to getting a cerebral-palsied child to feed himself, or a rearrangement of the furniture to provide greater play space.

While the parents discuss these ideas, they are constantly working on one of the baffling aspects of their problems, that of evaluating their child's particular timetable of growth and development. For many handicapped children, there is no set guide. Each parent has to find out what stage his child has reached, in relation not to age, but to the limitations imposed by his disability as well as to his capacities.

With the leader's encouragement, parents are often able to bring out the basic questions that lie behind these practical discussions, revealing a few central themes variously expressed. The common question, "How much can my child really do?" may be a front for many others: What is the true extent of his disability? What does this mean for me? How much should I do for him and how can I best help him learn to do things for himself? What is my real role as a parent, what kind of a parent do I want to be, and can I really carry out what I think I should do? Will he be able to take care of himself later on? What does the future really hold? Will I ever be free of this endless burden?

Whatever the parents begin to talk about may uncork a flood of feelings. Sometimes these feelings burst through in first or second meetings, sometimes they are held back until late in the series, when the parents feel more at ease. Parents often reveal in groups what they say they find it more difficult to reveal in one-to-one talks with doctors, psychologists, and social workers—especially their confusion about what they have been told regarding their child's disability. Often they say that they have not been told enough and that they have not been met with sympathy and understanding. The frequency of these comments even though the medical, nursing, and social service personnel are known to have been competent, thoughtful, and friendly suggests the extent of these parents' need for support and perhaps also their difficulty in absorbing the reality of what they face.

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Many parents gradually come to see the extent of this need as well as the unreality of their expectations. They discuss what may be pushing them to continue to "shop around"—the wish for a magic cure or a new diagnosis since the reality seems so unbearable. Yet at the same time they recognize that they must reach out for all the services available to the child and press for more if needed.

Other feelings emerge in different ways from group to group. There seems to be a strong, deep undercurrent of anger, frustration, and guilt that needs to find an outlet and breaks through whenever it can. Within the supportive atmosphere of the group, parents begin to talk about their anger and frustration, sometimes directed at the child himself but more often at medical services, random happenings or just fate. When they recognize that these reactions are shared by others and are accepted as natural by the leader and the group, they come to feel less guilty about them and are better able to look at them more realistically.

A similar process occurs when parents bring out their feelings of deep disappointment in their child, of having a constant, endless burden and, sometimes, of being drained of all individuality. They say again and again that they feel personally responsible for the disability, although rarely is there any justification for their self-reproach.

These complex feelings appear to be almost universal in our culture. They seem to flow from a basic part of our emotional lives, from our expectations and dreams, our hopes and fears regarding our children. The degree and expressions of such feelings, however, vary considerably, according to the parents' individual temperaments, the nature and severity of the child's disability, its causes and prognosis, and the special significance it may have for the parents.

Yet whatever these feelings may be, looking at them honestly with others who share them to some degree at least, seems to open the way for parents to accept themselves a little better and to be able to test the feelings against reality. This testing in turn seems to free them to gain a better understanding of all their family members' needs and of their own inner resources.

Some people, of course, are so caught up in their emotions that they cannot make use of group educational experiences of this kind. Therefore, some of the agencies in this project opened the groups only to parents who seemed to their social service personnel likely to profit from the experience. Others invited all parents on a general list of patient contacts to attend. Still others invited any parent in the general public who had a child with the particular disability. Whatever the method of group recruitment, the leaders were alert for parents who either showed no movement during the series or seemed disturbed by the discussions in ways the group could not be expected to resolve, and referred them to casework or psychiatric treatment services. However, some parents who presented a discouraging picture, during earlier sessions, eventually showed surprising shifts of attitude, often first moving out of their own preoccupations to help other parents in the group and then applying a new approach to their own problems.

Comparisons

How different are these group sessions from sessions with parents of well children? The association's staff believes that there is a basic similarity in the nature of the experiences for all parents, but that there is a marked difference in the intensity of the feelings expressed and in the quality and degree of parental concerns.

The range of questions that come from parents of children with handicaps are actually very similar to those raised in groups of parents of normal children. For example, parents of well children are also concerned about how much their children can do, how they can best help them to develop their capacities without pushing them too hard, on the one hand, or not giving them enough stimulation and encouragement, on the other. They too, often voice the disappointments they feel as they compare their children with the dream children they had looked forward to.

The difference lies in the reality behind the words, in all the complicating factors connected with the disability that so often leave parents of the handicapped child struggling to find their way alone day by day in dealing with their child and in coping with their own emotional reactions. The burdens of these parents are infinitely greater and the reality is much more threatening, both now and for the future. The practical choices open to them in such matters as schooling, family mobility, and social life for the children and for themselves are far more limited. The satisfactions of parenthood for them are less apparent, though they can find satisfactions if they can move past their difficulties to recognize them. For them the experience of parenthood is a constant problem, in which the concerns of other parents are greatly magnified.

And so the feelings, when they come, pour out in these meetings with greater intensity. This is true not only with parents who have recently been confronted with the problem of having a handicapped child, but also with parents who have lived with the problem for some years. In the case of the latter, one can only speculate as to why the intensity of feeling has continued. Perhaps these parents have never fully faced the shock of knowing their child is handicapped and so have not thoroughly lived through the crisis that comes with this knowledge. Perhaps, because of the constant demands on them, their lives seem to be one crisis after another. Perhaps they have never before had the chance to express what they feel.

Leadership Problems

Parents' feelings are an important part of any group educational experience, but the intensity of feelings of parents of disabled children present some leadership problems which are not unique to these groups but appear in exaggerated form. Once the dam of pent-up feelings gives way, it is often hard to stop the flow. How long should the leader allow the talk to continue in this vein? How much do the parents have to "get off their chests" before they can begin to look at the meaning of these feelings and learn to handle them better? When is it wise to help them out of the morass of emotions, so that they will not get stuck and only feed each other's self-pity? How can one do this without cutting them off before their feelings are fully relieved?

The answers to these questions depend on the leader's sensitivity to the reactions of the individuals in the group and on his judgment of the impact on them of the group interplay. He also makes use of his social casework knowledge of how and when to further a client's movement toward new insight.

Some group leaders with a background of social casework became uneasy when the parents spilled over their strong and often hostile feelings. Although they were prepared to handle such outpourings in a casework interview, they were afraid they might not be able to handle them in a group. As they gained more experience and worked on the problem with their child study consultants, they found that these outpourings, like any other material presented by the parents, could be discussed within the group and used to good advantage, even though difficult moments might occur. They discovered too that the situation is often eased by the spontaneous, self-regulating dynamics of the group; that the members themselves pull away when the impact of the discussion is too heavy and often support and reassure a parent who may be revealing too much. They found too that the leader can step in when necessary, to put the parent's revelation into a more impersonal framework, by universalizing it with a sympathetic comment or directing the discussion into some other, more general, area.

These parent groups have exhibited considerable variation in mood. In some, the mood apparently stems from the chance combination of personalities, but, in others it seems to be related to the nature and severity of the children's disability. For example, the meetings of a group of parents of severely cerebral-palsied and mentally retarded young adults were noticeably depressed in tone. These parents had lived with their children's problem for 20 years or more and saw no hope of improvement.

The leader of a group like this faces the danger of becoming caught up in similar feelings. He can, however, guard against this and try to help the parents talk not only about their heartaches and problems but also about what they have accomplished for their sons and daughters and for themselves.

Helping parents examine their successes as well as their failures is basic in all parent group education. In groups where the parents face especially tragic situations the attitudes reflected in the group tone are often fixed and hard to shift. The group works slowly as though in low gear. Yet a skillful leader who makes full use of group support and sympathetically encourages the parents to look at different facets of their experiences, can help the parents achieve another perspective and, sometimes, a little break in mood. Such groups, however, might be encouraged to meet for more sessions, and their members should perhaps be offered periodic casework contacts.

Mixed Groups

Other variations in group movement are found in groups composed of parents of children with different disabilities or children who have a similar disability but a wide range of impairment. The basis for these parents coming together is that they share the common experience of having a handicapped child, but differences in the nature or degree of the child's handicap may set each family off in a separate category. Even in groups built around a common label, such as mental retardation or orthopedic handicaps, parents often become preoccupied

with the fact that their child is much more (or less) disabled than the children of the other group members. Whether they are deeply envious of the other parents or relieved at their own favorable situation, their awareness of the differences makes it hard for them to see and share their common problems and so to learn from one another. These groups too work at a slower pace and require unusually sensitive leadership.

Experience so far suggests that parent groups function more effectively if they focus on children whose disabilities are fairly similar and who are within a defined age range. However, in groups of parents of the handicapped, the age range of the children can be wider than in groups of parents of well children, who follow a developmental timetable much more closely. More experimentation is needed before one can begin to assess adequately the advantages and disadvantages of homogeneity and of problems in these parent groups.

Leadership Techniques

All parent groups require a flexible and creative use of group leadership techniques to meet the needs of the particular parents in the group. The charge of parent group education under any circumstances is to use these skills to further the parents' total understanding of their children, of themselves as parents, of parent-child relations, and of the interplay between the family members. With parents of handicapped children there is the added factor of the handicap and its effect on all the family, as well as on the disabled child. But the approach to these parents involves the same goals and techniques as to other parent groups, consciously applied to their special needs.

Social workers are especially well equipped for leadership of these parent groups as they bring to the task a rich background of knowledge and experience with individuals and families and a keen understanding of the dynamics of behavior. Those who have participated in the training projects have also brought a thorough knowledge of the specific disabilities involved and their implications for children, though they have not always seen the children clearly against the background of normal child development. Sometimes out of eagerness to see that the children are helped to develop as far as possible, they have overlooked their emotional needs as children. Some have found it difficult to maintain a balance of empathy and have tended to identify either with the parents or with the children.

At first some of the social workers were preoccupied with and somewhat fearful of the group approach. As a result, at times they failed to recognize the way in which they were already carrying out the objectives of the program in basing their leadership on social work concepts, adapted to the group and directed along broadly educational lines. In time, however, they came to realize this and their leadership skills developed with a new spurt.

Several social workers have reported that the program has sharpened their casework skills by sensitizing them to listening more thoughtfully for the deeper concerns of parents of the handicapped. They have also said that they now recognize more clearly that these parents are able, within a guided group experience, to develop strengths which they can consciously use to help their handicapped children.

[1] Auerbach, Aline B.: Group participation in expectant-parent classes. *Children*, May-June 1958.

. . . We'd better face it. We will either help our young people to find great dreams to work and live for, or they will give us nightmares to live with. Man must have adequate opportunities to create according to a dream. Denied them, he will destroy out of the dark, blind impulses of the nightmare of frustration.

Rev. Donald Harrington in a sermon at the Community Church, New York.

A large public agency involves all levels of personnel in . . .

A DEVELOPMENT PROGRAM FOR CHILD WELFARE STAFF

CAROL H. MEYER

Director of Training, Bureau of Child Welfare
Department of Welfare, City of New York

FOR THE PAST 3 years the Bureau of Child Welfare of the New York City welfare department has been using Federal child welfare services funds for a training consultant to devise and administer a demonstration staff development program growing out of the practice and staff needs of the Bureau of Child Welfare. In this time we have gained sufficient experience to reflect upon the values and hazards of an inservice training program in a large urban public child welfare agency. While the New York City agency has special problems because of the size of its client population and of the staff necessary to carry out its multiple functions, the introduction and conduct of the staff development program encompasses principles of such a generic nature in social work practice that examination of its experience might well interest agencies in other communities. We have gained some successes and have skirted some failures, but the hunger for staff development and the observance of a basic social work process in devising and carrying out the program seem to have won out over the obstacles.

The Bureau of Child Welfare serves over 12,000 families and is responsible in a variety of ways for about 24,250 children in foster care and in day care. It has a total staff of 1,417 persons, of whom 548 are social service staff; 588 administrative, clerical, and other staff, including educational consultants in day care, institutional aids, and a variety of auxiliary personnel; and 281 children's counselors in 3 temporary care shelters. The Bureau operates through nine separate divisions, each carrying out a separate part of its extensive functions: study and exploration, prevention and placements; administration and supervision of child placements made by the Bureau through voluntary agencies and institutions; direct foster home care, adoption, temporary care, and day care of children; and services to unmarried mothers. Thus the wide variety of services presents a tremendous challenge to efforts at staff development.

We are working at this time only with the social service staff, but we anticipate that eventually the supportive staff will also become involved in the program. The social service staff includes 397 social investigators or field workers, 75 unit supervisors, 25 case supervisors, 11 senior supervisors, 9 division directors, and 5 administrative staff. Of the total, 57 have completed their professional social work education and another 35 have completed 1 year of professional training. Through the benefit of Federal funds for child welfare services, we are able to send from 20 to 30 staff members to schools of social work each year, but even without taking into consideration the inevitable loss of some of these trained staff, we could not anticipate a fully trained staff for the Bureau of Child Welfare in less than 20 years. Realistically speaking, we must expect that for many years most of our social work staff, partic-

ularly on the practitioner level, will not have professional education.

There is an annual turnover rate of about 38 percent among the social investigators, while the supervisory and administrative staff remains somewhat stable. This means that the bureau must hire about 150 social investigators a year, thus requiring a large amount of the staff development effort to be spent in the orientation and training of newly hired people. One may ask where else the training effort could more appropriately be placed? This question, the way in which we have defined staff development, and the reasons for our increasing attention to the learning needs of supervisory groups, will be dealt with as we describe the purposes and methods of the staff development program itself.

Staff development in the Bureau of Child Welfare has been defined as the development of the practices of all staff—social service, institutional, and clerical—that directly or indirectly affect services to families and children. Thus, staff development is a term applicable to the experienced and the newly hired, the professionally trained and the untrained, since it does not necessarily imply "training" for a job, but rather, refinement or deepening of knowledge and skills in whatever level of staff such educational need exists. *Inservice training* has been defined more narrowly as direct teaching to new staff of the job to be done within the bureau's structure. Since within the closed civil service promotional system only the first level of social work staff, social investigators, are brought into the bureau from outside, inservice training has been confined to newly hired social investigators.

According to these definitions, the larger purposes of staff development are achieved only as supervisory staff and administrators examine and gradually improve their practice. Inservice training, while essential to the operations of the bureau, is decidedly more limited in its aims, since it affects a portion of staff composed of persons whom we are never sure will remain with the bureau, and whose educational needs for a period of time are restricted to learning the rudiments of the social investigator's job.

According to the major premise of the bureau's staff development program, its lasting effectiveness will stem from the continuous involvement of the *total* staff in the learning and teaching of the social work attitudes, knowledge, methods, and skills of sound child welfare practice. Thus, it has been our task to conceive of a program that would be sufficiently flexible to accommodate itself to practitioners in all stages of experience and to three levels of supervisors representing a wide range of educational preparedness. The content of the program has had to be generic enough to serve the practice needs of the total bureau, and specific enough to meet the interests of each of the nine administrative units. The methods used in carrying out the program have had to be effective for all elements of staff without interfering with the operations of the bureau, holding out something new without at the same time threatening to eliminate the familiar.

The Process

The process through which the program has been developed contains similarities to the social work process itself as this is characterized by certain basic concepts and philosophical tenets and the use of the scientific method.

First, the learning needs of the staff had to be studied and assessed in the light of the purposes and practices of the agency and the stage of development the staff had reached. Second, the obstacles to staff development inherent in the agency and the staff had to be understood or "diagnosed" so that our program could at the least adapt to these resistive areas and pursue appropriate and reasonable goals. Third, the resources within the agency and the potentialities within the staff had to be evaluated in relation to what the program might offer.

Finally, on the basis of these assessments, we determined to proceed with a variety of methods, each geared to a particular level of staff and its special area of responsibility. In keeping with our premise that the staff itself had to be directly involved in the planning, carrying out, and evaluation of the program, our chief efforts have been directed to all supervisory staff who have continuing administrative and teaching responsibilities and upon whom rests the burden of the bureau's practice.

Whereas adherence to this underlying premise of participation has meant that staff development began slowly, remained on a fairly low educational level for a time, and required an inordinate amount of planning, the results have indicated that this gradual process was a sound way of introducing the program. We have not relied upon lectures from outside the agency, despite the wealth of professional talent and resources in New York City, nor have we introduced formal teaching within the agency. Instead we have depended upon agency workshops that have been geared entirely to the staff's readiness to review what they knew and to absorb new material. We did not

model an inservice training program upon already tested syllabuses, but rather devised a limited central training plan and placed the burden of teaching upon the supervisors themselves. We have not encouraged staff to attend institutes offered in the community unless they can integrate what they have gained back into their agency practice.

We have found that the bureau has its own resources for staff development as does every public agency—staff that can be encouraged to teach, and thus learn—and professional and educational purposes that derive from the work of the agency itself. However, we have proceeded on the theory that for these resources to prove useful to the staff, agency, and community, there must be some administrative responsibility for keeping staff development in continuous touch with social work developments occurring outside of the agency, so that the content of the agency's program does not become sterile but stays continually enriched.

We have demonstrated that these methods of staff development can be integrated into the administrative and supervisory structure of an agency and that it can be flexible enough to adjust to agency function and operation, and staff readiness and interests.

Finally, and probably most important, we are finding that such a program carries its own insurance for continuity. If a staff development program derives merely from experts within or outside of the agency, there is no guarantee that when these experts are removed there will continue to be a staff development program. On the other hand, where a large proportion of the staff itself is participating in the staff development process, with administrative leadership, this will become as much a part of the staff's normal functioning as the direct practice in which they are continuously involved.

So far the groups to which the bureau's staff development program have been directed have been: newly hired social investigators, unit supervisors, case supervisors, and senior supervisors. In another year we will be experimenting in reaching the staff through other kinds of groupings. In the first years of the program, we followed the groupings of the civil service classification system, as this arrangement was clearly acceptable to the staff.

Because of the high turnover in social investigators, we must train an average of 35 to 40 new staff every 3 months in order to keep the bureau fully staffed and caseloads covered. If this turnover decreases with increased staff interest in the work and anticipated changes in working conditions and salaries, we intend to hire staff at longer intervals—hopefully as long as 6 months, so that we can sustain a 6-month training period for all newly hired social investigators.

Induction of New Workers

These workers are all college graduates. Some have had social work experience, but usually none have had even one class in a school of social work.

Orientation takes place in 1 day, during which we describe briefly the work of the Bureau of Child Welfare, its place in the Department of Welfare, and its personnel practices, and only those aspects of the job that are essential for the workers to get started. We rely heavily upon the groups' questions to let us know about the members' knowledge, experience, and sophistication.

After the orientation session the members are assigned to training units in different divisions of the bureau to begin their training and work. We have restricted the orientation period to 1 day out of the conviction that newly hired workers are overwhelmed when they arrive and cannot absorb nor retain any material that is not directly related to their immediate situation. In addition, we believe that new staff learns best on the job, and that waiting during an extended orientation period tends only to increase tension and anxiety.

In addition to being taught on the job in their training units, the new workers meet together in central training sessions for 2-hour training sessions once a week for about 3 months, although we would extend this if the 6-month training period were to become a reality. The educational goals of these central training sessions are limited, as we believe that integrated learning in social work takes place through supervision of practice. An operating agency of this size, with a wide range of quality in supervision and a great deal of work pressure, cannot and should not teach new staff theories that cannot be assured of support by the supervisors in day-to-day practice. When training sessions heavily weighted in theory are directed only to new staff, supervisors fail to become involved in the same learning as their investigators. The results of "overteaching" new staff is more often threatening to the supervisors than enlightening to the new workers.

We attempt to achieve three specific purposes in the weekly training sessions:

1. Provide an opportunity for new staff from all divisions to meet together to become identified as bureau staff and at the same time to become

exposed to the various functions of the bureau.

2. Teach that general content of the basic social study which relates to every bureau case. This approach serves to introduce or reaffirm the points being made in supervision in regard to specific cases.

3. Develop positive attitudes about any part of social work theory and practice to which new staff is exposed. We have recognized that it will never be possible to include all the social work substance that new social investigators need to learn, nor to time sessions so that they will meet the immediate practice needs of staff. Also, in keeping the central training sessions on a general and conceptual level, we recognize that the use to which social investigators put their new knowledge will not be evident right away. Our chief purpose will have been met if we succeed in developing in new staff a general attitude of readiness to learn new things and new ways of working with people.

Training Units

In accordance with the staff development program's basic premise that training opportunities should grow out of the bureau staff and practice, the program's major emphasis is placed upon on-the-job training in the training units established for newly hired social investigators. These units have served multiple training and administrative purposes.

While there have been great administrative difficulties in working out the training unit plan, the advantages have decidedly overbalanced the disadvantages.

As for positive results:

- The training unit plan has made it possible to greatly reduce the numbers of supervisors who are involved with new staff. This has resulted in an extraordinary saving of administrative and clerical time in planning the new workers' training program. Only 10 to 15 supervisors rather than 50, have to be consulted.
- The plan has made it possible to select for the program only those supervisors who are well qualified to teach, who favor an educationally focused supervisory approach, who are motivated to be training supervisors, and who want to give attention to the special learning needs of newly hired workers.
- Under the training unit plan supervisors can teach general basic material to several workers at once instead of having to repeat this material to each new worker individually as he enters a regular unit.
- The plan has made it possible in most instances to select the cases for assignment to new workers on the basis of their usefulness in providing opportunities for the development of learning from simple to complex tasks.

Thus the training unit system has not only singled out the educational focus for newly hired staff, but it has also relieved the nontraining supervisors from the continual pressures of teaching new staff.

The problems presented by this training unit plan have stemmed chiefly from staff shortages. Obviously the carving out of "protected" units in the operating divisions of the bureau means that the workers in the remaining units have to absorb the pressures of coverage. Sometimes these pressures become so great that they are of necessity moved back to the training units, and while the training unit supervisors have responded to this by quickening their pace with the new social investigators and assigning larger caseloads when necessary to provide coverage, the gradual procedure of the educational process naturally has been affected. This might be regarded as a severe hazard to on-the-job training, unless one accepts the fact that even work pressures are part of the reality for which new staff must be trained.

There have been other administrative problems in regard to this new program as well as some natural resistance among staff, but the greater our experience with training units, the fewer difficulties appear. The bureau's current policy is that newly hired social investigators must be assigned to training units with selected training supervisors. Thus after a year of demonstration, the units have become an integrated part of the bureau.

Training Unit Supervisors

Training units have led naturally to the opportunity for us to work rather intensively with the training unit supervisors. From the beginning of the training unit plan, its administrative details were worked out with these supervisors, and the content and method of educationally geared supervision were developed continually through ongoing supervisory workshops. These supervisors not only have participated actively in all aspects of their new teaching role in the Bureau, they also have carried a major part of the development and continuing evaluation of the central training sessions—determining the nature of the content of these sessions as differentiated from the content of their sessions with the new workers in their units. They have, in fact, demonstrated the validity of our basic premise that staff development appropriately involves staff participation in every aspect of the program.

Since the training unit supervisors carry the chief responsibility for direct teaching of new staff, we have made many efforts to enrich their learning as well as that of the new workers. In the course of our exploration of learning needs in the bureau, we found among social investigators, a serious deficiency in their understanding of human behavior. Since we could not hope to send our 397 social investigators to schools of social work, and moreover, believed that learning at their level should take place on the job through their supervisors, we arranged for a school of social work to provide a noncredit extension course in human growth and behavior for the training unit supervisors. The course was also open to supervisors who would be supervising the workers in the posttraining unit phase of their early experience at the bureau—a beginning effort to follow through and continue the training atmosphere for newly hired staff as they move on to increased responsibility.

The purpose of the course, which is conducted jointly by a psychiatrist and a teacher of social work, is to present and clarify the theory of human growth and behavior so that the supervisors can transmit it appropriately to the investigators in the course of their supervisory work. The supervisors attend the course for a full semester on agency time, the cost being borne entirely by Federal child welfare services funds. Since about one-third of them are graduate social workers and an even greater portion have already taken courses in human growth and behavior, the course's basic content is not new to most of them. Its focus on teaching, however, is new.

In order to insure the integration of the course material into agency practice, the supervisors meet in a workshop biweekly at the agency to consider specific ways of applying its general content in their specific supervisory practice. Since this phase of the program is still in process, we are not able to present our final impressions, but we believe the course has already stimulated a rich kind of thinking which will have its impact upon practice.

Aside from the program for the training unit supervisors, we have conducted regular workshops for all other unit supervisors—emphasizing the individualization of workers through the educational diagnostic methods of supervision.

The supervisors in the Bureau of Child Welfare know the job of the social investigator well. They are expert in knowledge of agency function and policy, and are becoming increasingly knowledgeable about sound social casework and child welfare practices. The chief area in which they need development, an area rarely emphasized in formal training, is methods of supervision—how best to teach staff and develop the worker's ability to operate with increasing independence.

We have concentrated on this area of staff development during the last 2 years. Perhaps in the next year we can move on to other areas and confine the development of supervisory methods to newly appointed unit supervisors. Our experience with these workshops has demonstrated that staff will rise to the opportunity to think and to learn, to reach for new ideas, and to participate wholly in the total learning experience.

Higher Staff

As one observes the various levels of staff in a public welfare agency, it becomes evident that the higher up the scale in the civil service promotional system, the older and more experienced the staff becomes and the further away from direct practice. Yet the group that should be most deeply concerned with staff development is the case supervisory staff. Just as the burden of practice has to be placed upon the unit supervisors who are the stable group of staff closest to practice, so the broader responsibility for improvement of both casework and supervisory practice ought to be assumed by the case supervisors. Therefore, before we even began to plan a program for unit supervisors, we involved the case supervisors in the development and evaluation of the supervisors' workshops. It took a little longer for the case supervisors to consider their own part in staff development, but after 2 years they too succeeded in using the opportunity provided to rethink casework practice.

Through a continuing series of meetings during the past year, the case supervisors reviewed and sifted every printed form used in the bureau, developed recommendations for modifying the use of a good number of forms, and suggested principles for the ways in which necessary forms might be used more productively by social investigators. At the present time the group is deeply involved in taking a fresh look at case recording in the bureau, examining the practices that the recording reflects, and considering the formulation of new goals in service that respond to the most up-to-date philosophy of child welfare practice. In the process of their meeting together, the case supervisors have been discovering a creative role for themselves in this overburdened bureaucratic structure. Perhaps soon they

will no longer tend to view themselves merely as the third step up and third step down in levels of approval, but rather will recognize the special contributions they can make to the improvement of the bureau's practice.

The bureau's smaller group of senior supervisors serve as assistant administrators to division directors, their particular tasks residing in administrative areas. The administrative knowledge and experience in the senior supervisors' group have been tapped gradually in the staff development program, as we have observed specific areas that need attention. Last year the group met for many months to develop a report on ways of streamlining the social investigator's job. The focus of the case supervisors' work this year on forms and recording was a direct outgrowth of other recommendations the senior supervisors made. We are now contemplating the possibility of this group's undertaking a complicated plan to involve all levels of staff, but particularly experienced social investigators in all divisions of the bureau to develop a manual of practice for social investigators.

Administration

We cannot conclude a description of the bureau's staff development program without mentioning the part administration has played in carrying it out. The program could never have taken hold in the bureau without the deep conviction on the part of and administrative staff that "training is essential," but probably every agency administrator believes in such an axiom. It is when the theory is put to the test that one knows whether or not there is real support for staff development. When supervisors leave their desks to attend workshops and an extension course, when newly hired workers are started with only three cases in a division that has a dozen uncovered caseloads, when conflicts of time and interest appear, and when operation slows down to permit the entry of new ideas—then one knows that the step has been made, from abstract agreement with an idea to absolute professional support in the face of sacrifice, extra work, and the anxiety that accompanies the unknown.

Will this work? Will staff development become a state of mind and percolate through the agency? Will it help to retain staff or will it deplete staff even more by raising their sights and encouraging them to go to school and then to leave us for higher salaries? Is it best to have this program depend so utterly upon a gradual social work process, or should we implement a faster and more dramatic program involving outside experts, formal institutes, greater attendance at outside meetings, and the like?

The answers to these questions are appearing in the day-to-day responses of the staff to a staff development program that is already part of them and of their own making. The supervisory staff seems to have an inexhaustible willingness to examine their practice and their methods of supervision. In their natural reaching for new ideas they sometimes hesitate, but ultimately demonstrate their resiliency.

Staff development cannot help but be a dynamic process while staff itself is dynamic. However, assurance of the success of a program such as ours rests upon clear administrative support which must appreciate this dynamic response and must provide an atmosphere where imagination and experimentation can flourish; where the staff itself is honored. In an agency where there is the conviction that sound child welfare practice will derive from free inquiry into new ideas and knowledge, and where there is regard for the staff's own experiences and potentialities, a staff development program will grow out of staff need and desire. Such a program then cannot help but reflect the purposes and the practices of the agency.

Instead of becoming irritated and defensive about the labels of "do-gooders" and "proponents of the welfare state," we should accept them with pride, while asking what's wrong about doing good and urging a state of general welfare.

Whitney Young, Jr., to the Intergroup Relations Committee of the National Social Welfare Assembly.

SOME FACTORS IN ACHIEVING PSYCHOLOGICAL MATURITY

JOHN H. ROHRER

Professor of Psychology, Department of Psychiatry, Georgetown University School of Medicine

IN 1952, Allison Davis and John Dollard made available to the staff of the Urban Life Research Institute of Tulane University (New Orleans, La.) all of the original interview materials they had gathered in 1938 in a study carried out on a group of adolescent Negro youths in New Orleans. A part of that material had been published in their volume, "Children of Bondage." [1] The institute then formed a research team composed of a sociologist, an anthropologist, two psychologists, and two psychiatrists to make a followup study of this group. The study was carried out over a 3-year period. The major findings of this study are to be found in a volume entitled "The Eighth Generation." [2]

It is not my purpose to review that volume in this brief article. Rather I wish to point out some of the implications of the study's findings for a better understanding of the way an individual achieves some degree of psychological maturity.

In the study we tried to develop scientific descriptions at three different levels: the level of cultures; the level of social structures; and the level of intrapsychic functioning. We then attempted to integrate the findings at the three different levels into a coherent pattern explaining the lives of our subjects.

Negro culture in New Orleans is a fairly well integrated and mature one, having had eight generations in which to evolve. Certainly when one contrasts the degree to which the culture has become stabilized there with Negro communities in some other American cities, for example, Chicago, one is struck by the maturity of the New Orleans culture. Even so, this culture is not homogeneous, for we were able to identify at least five distinctive subcultural groups among our subjects differing markedly from one another in their value systems and their ways of life. Since our sample was preselected for us, we may have missed other subcultural groupings within the New Orleans Negro community—for example, an upperclass culture, of which the beginnings are now evident.

We were able to identify these subcultures through the study of five file drawers of material that we had collected on our subjects, identifying for each person we had interviewed what we call a *primary role identification*. By this we meant the central social role around which the person organized his secondary, tertiary, and other valued roles, and around which he organized his psychic economy.

For one group of subjects the subculture was the *matriarchy*. In this group the primary role identification was that of being a woman and was characterized by intense emotional feeling between mother and daughter, who presented a solid front, particularly when it came to excluding the male sex. Even when married, the daughters in this group saw their mothers as the center of their lives and security.

For another group the subculture was the *gang*, and the central role identification was that of being a man and being independent from mother, from wife and children, and, frequently, from occupation. The gang members had nothing but scorn for anything feminine, and particularly for effeminate men.

Another group was *family oriented*, the lives of the people in it revolving primarily, or even exclusively, around the family. For these men and women, family life was the most important part of all life, and family solidarity the most important value.

For another group, the orientation was *middle class*. For these people the things most valued were achievement, responsibility, respectability, politeness, industry, and kindred virtues.

As always when one is attempting to compartmentalize the complexities of human behavior, we had a residual group that we labeled *marginal*.

Thus we were able to demonstrate that for most people there is a central core role which is most highly valued and around which an individual orders

all the rest of the behavior in which he engages. The selection of the central role identification, and the satellite roles which complement and support the central role, actually places limits on the different kinds of behaviors in which the person can engage. The values listed here for what we called our middle-class group indicate a range of behaviors that would make it impossible for a middle-class person to adopt the behavior of the gang-oriented person, and the values of the gang, in turn, would prevent a gang member from engaging in middle-class behavior.

It is this patterning effect that identifies the subcultures. The demonstration of the existence of such subcultures, even within one ethnic group, points to the considerable danger of making broad generalizations about the value systems and the ways of life of any ethnic or regional group.

A Factor in Mental Health

In the course of our work we gathered considerable information on the mental health of our subjects, although that was not the primary aim of our study. One of the most striking correlations we found between "good" and "poor" mental health was the relationship of our subjects during childhood and adolescent years with more mature individuals. Those individuals who had had significant adults in their lives providing them with emotional support in times of stress invariably were in a state of good mental health at the time of our study; those who were unfortunate enough not to have had such significant adults to provide emotional support were in poor mental health.

While in some cases the significant adult—the "ego ideal"—was a parent or parents, in others it was perhaps an aunt, a more mature cousin, or just a friend. Nor were these adults always of the same ethnic group. In one of the most striking success cases of all the subjects that we studied, that of "Little Bit" who turned out to be an internationally known dancer, the significant adult had been a white Dixieland band leader.

Another finding grew out of our decision to attempt to predict, from the early adolescent materials what the young person would be like as an adult. During our study each subject was seen by only one of the two psychiatrists. The other psychiatrist went over the old interview materials gathered some 15 years earlier and made "blind" predictions about what the individual would be like as an adult.

These predictions from the adolescent materials were based largely on the major types of ego defenses used, the types of gratifications sought, the dominant motivations exhibited, and the ways of relating to members of the same and opposite sex.

These predictions turned out to be amazingly accurate. The psychiatrists were able to predict in nearly all the cases the type of occupation a person would engage in, the level of education he would achieve, whether or not he (or she) would marry and, if so, the type of person the spouse would be and the degree of stability of the marriage. They were also accurate in predicting the habitual ways in which, as adults, our subjects would go about handling problems or conflicts.

Since the psychiatrists were using only the materials gathered during the subjects' adolescence on which to base their predictions, the accuracy of their predictions was interpreted to mean that an individual's techniques for maintaining his self-integrity and his ways of defending and enhancing himself were firmly established by adolescence. This underscores the considerable importance and significance of childhood and early adolescent development for the quality of achieved adult maturity.

In Summary

There are, of course, a multitude of factors that influence the achievement of psychological maturity, and I do not intend to indicate that the three basic factors mentioned here are all-inclusive. However, these three factors are fundamental to the achievement of any degree of psychological maturity. Everyone inevitably carries a number of social roles, some of which he identifies with more strongly than others. Everyone also, even after passing the great dependency of infancy, continues to have a need for warm emotional support during his formative years. Withdrawal of such emotional support, or failure to obtain it in times of stress, blocks the individual from becoming more mature. Finally, the fact, as evidenced by the predictions made by our psychiatrists, that the typical ways of adjusting to the world in which one finds one's self are established at least by early adolescence, indicates the great importance of these earlier years to the psychosocial maturity of an individual. This finding also indicates why it is a long tedious job, whether by counseling or psychotherapy, to modify these established, habitual ways of self-defense and enhancement.

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[1] Davis, Allison; Dollard, John: Children of bondage. American Council on Education, Washington, D.C., 1940.

[2] Rohrer, John H.; Edmonson, M. S. (editors): The eighth generation. Harper & Bros., New York, 1960.

An essay-review . . .

HELPING THE TROUBLED CHILD IN RESIDENTIAL TREATMENT

MARTIN GULA

Specialist on Group Care, Division of Social Services, Children's Bureau

WITH A BURGEONING population of over 64 million youngsters, our country is finding it increasingly difficult to identify, diagnose, and treat its emotionally disturbed children. Many such children remain unnoticed until adolescence when treatment is difficult. Many are identified and their condition diagnosed but never receive treatment because services are lacking. This gap between children in need and available resources will widen unless new methods are developed for locating and helping emotionally disturbed children and their families.

Currently, many individuals are involved in community efforts to keep children emotionally well—parents, teachers, ministers, doctors, psychiatrists, psychologists, social workers, and child care workers. Some communities have also developed a variety of resources for those who show symptoms of disturbance, including outpatient clinics and services and day hospitals.

Even with the best of community resources and outpatient services concerned with the emotional health of children, some emotionally disturbed children must be separated from their families for care and treatment. Many are being cared for in residential treatment centers, voluntary hospital psychiatric facilities, State and metropolitan mental hospitals, training schools, and child-caring institutions of various kinds. Unfortunately, many of these emotionally disturbed children are committed to State hospitals for adults or training schools and children's institutions which do not have adequate clinical facilities and coordinated treatment service.

However, a small but growing number of residential treatment centers have devoted themselves to creating therapeutic settings for the treatment of disturbed children and counseling or treatment of parents. Some of these centers are sponsored by medical or mental health organizations. A larger number have been developed by child welfare organizations.

One result of intensive welfare efforts is Hawthorne Cedar Knolls, a residential treatment facility promoted by the Jewish Board of Guardians in New York. Since 1935, Hawthorne has experimented with a variety of therapeutic disciplines for developing a constructive treatment setting for children. The integration of these disciplines is described in "Residential Treatment for the Disturbed Child," [1] by Herschel Alt, executive director of the parent organization. In his words, ". . . the roots of residential treatment are to be found in many fields of social and psychological service, as well as in the child-rearing disciplines."

Several other efforts have been made to identify these elements of residential treatment. [2,3] They include the following: selective grouping, concurrent help for parents, individual psychotherapy, group care, group therapy, remedial education, somatic therapies, and medical services. Listing the elements is comparatively simple. The challenge is how to coordinate and integrate these elements in such a way as to offer the greatest benefit to the individual child and the resident population as a whole.

An Integrated Program

At Hawthorne, such integration is pursued vigorously. "The child is one and indivisible, and if the specialized services are to contribute most to his healing and growth, each distinct function must be

in harmony with the others." A variety of integrative devices are used: "initial and followup conferences on individual children, inservice seminars, a common educational base which comes from similar training and also . . . incorporation into the milieu of common attitudes and values." Professional supervision is provided for cottage parents, who participate in case discussions and in general policy decisions about care of children. The institution has been subdivided into small treatment units ". . . which makes for more focused efforts" and "also helps to facilitate communication, common purpose, and consistency of effort."

Although many gains have been made in integrating staff treatment efforts, Alt believes that much more has to be learned about the interaction of specific child care procedures and clinical treatment in a total treatment plan. "The important thing, too, in addition to the warmth and investment in the concern for the real child and his total life, is that the institution maintain a philosophy which both totally and uniformly incorporates basic mental health principles. This does not mean transforming the whole institution into one large therapy room, nor does it mean indifference to the discrepancies between what is expected in real living and what can be allowed in the therapeutic relationship."

It is probably safe to assume that no two residential treatment centers will arrive at precisely the same theoretical formulation of their treatment base and methods of integrating all aspects of treatment. However, the important goal is for every treatment center to begin to be conscious of the way it is developing its internal practices and its relationship to external community services for disturbed children.

Herschel Alt's description of the development of Hawthorne Cedar Knolls could inspire some soul searching in other treatment centers. His frank discussion of theoretical and practical limitations is a warning to those professing to have unqualified "answers." The example of Hawthorne's embracement of many social, medical, psychological, psychiatric, educational, and child-rearing disciplines could be stimulating to those facilities with narrower reliance on fewer disciplines. The description of Hawthorne's purposeful relationship to other agency and community services for disturbed children should help to counteract the isolated role of some residential treatment centers. Hawthorne's emphasis on evaluation of treatment and research is basic to good treatment.

Case Illustrations

One way to gain an understanding of a residential treatment center is to study its treatment of an individual child and his family. Herschel Alt does this for three children in the book. The treatment of "Lenny," for example, began with a severely delinquent, apparently psychopathic youngster. Lenny's delinquency was an "accepted way of life." He had little guilt or anxiety, little capacity for relating to people constructively, and "requirements for effective psychotherapeutic intervention were absent."

Lenny's behavior included gang fights, truancy, running away from home, and car stealing. Hawthorne discovered that Lenny had strong hostility toward an itinerant mother and a fear of being "no good." He took it out on the world with a "big-shot" attitude and aggressive acts. Treatment of the boy involved a fascinating interplay of a warm, strong cottage couple; a therapist who could not be "outwitted;" confronting Lenny with his emotional patterns; an "incorruptible" school; and "boxing" the boy in by total staff when necessary. After 2 years at Hawthorne, Lenny returned to live with his mother, obtained and held a job, and did not—at least up until the time the book was written—become involved in any further delinquency.

Hawthorne has its failures too. But a case like Lenny's illustrates that even children who at first glance seem to have few strengths to build on can be helped to emotional stability with a careful combination of the various aspects of treatment available in such a comprehensive and integrated program as this residential treatment institution provides.

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[1] Alt, Herschel: Residential treatment for the disturbed child. International Universities Press, New York, 1961. $7.50. 437 pp.

[2] Reid, Joseph H.; Hagan, Helen: Residential treatment of emotionally disturbed children. Child Welfare League of America, New York, 1952.

[3] American Psychiatric Association: Psychiatric inpatient treatment of children. Washington, 1957.

HERE AND THERE

Adolescent Health

The broad vista of special health services for adolescents in this country was explored in an exchange of ideas and stocktaking by 65 professional workers from 15 adolescent clinics who met in Denver for a 2-day Conference on Adolescent Medicine in mid-April 1961. Sponsored jointly by the Division of Maternal and Child Health of the Colorado Department of Public Health and the University of Colorado Medical School, the conference brought together pediatricians, internists, psychiatrists, medical social workers, nurses, psychologists, research workers, and nutritionists. The discussions revealed that:

• Patterns of staff composition in adolescent clinics vary widely according to the kind of facility in which the clinic is set up—in a psychiatric unit, for example, or in a university's pediatric outpatient department—the older clinics generally having a greater variety of disciplines than the newer.

• Adolescent units not giving primarily psychiatric services are alike in that they see all children from 12 to 18 or 21 years of age referred to the hospital's outpatient department except those admitted for acute diagnosed disorders or emergencies. A pediatrician or internist becomes the adolescent's "own physician" to whom the specialists are then consultants. Nearly all such clinics have medical social workers on their staffs.

The discussants emphasized the close association between medical problems which are normal for the adolescent and those that are social or educational; the many areas in which norms for this age group need defining; the value of close rapport with community agencies and individuals working with youth; and the need for delineating goals and responsibilities for nonpsychiatric help to the adolescent coping with emotional difficulties.

Research was reported as ongoing or planned in the fields of language development, nonachievers in education, anthropomorphic measurement standards; correlation of onset of puberty with other physiologic and psychological developments; relationships of self-perception and emotional dependence with social behavior; the thought-style of the adolescent and the relationship of problem-solving abilities to other behavior, to metabolic and physiologic effects on mental and behavioral functions, and to genetic makeup; endocrine patterns as related to nutritional habits and to growth and development; school readiness; and methods of professional communication with adolescents.

Agreement was virtually unanimous that the need to know more about adolescents while trying to meet their special requirements justified having special services for them. The participants also agreed, however, that by so specializing there is a danger of not maintaining the reality of a continuum of care based on the normal continuity of growth and development from infancy to adulthood.

—Georgia B. Perkins

Unemployed Youth

The existence of thousands of unemployed youth in the slums of our large cities is "social dynamite," said James B. Conant, scientist and educator, to the 400 persons who met together in Washington, May 24–27, at the Conference on Unemployed Youth in Urban Areas. Convened by the National Committee on Children and Youth, and financed by the Ford Foundation, the conference drew participants from 38 States with a planned concentration on 15 of the country's largest cities. Besides representatives of the National Committee and its constituent organizations, the participants included representatives of labor and industry, educators, employment counselors, social workers, public health personnel, and local youth committee executives and members.

Dr. Conant, who served as chairman of the conference, told of his shock in learning on visits to several large cities that the employment of youth is "literally nobody's affair." He described a slum section composed almost entirely of Negroes where 59 percent of the male youth between the ages of 16 and 21 were out of school and unemployed—48 percent of the male high-school graduates and 63 percent of the boys who had dropped out of school. Unless management and labor take up the challenge to provide jobs for these young people, who now can see no pathway out of the slums, Dr. Conant said, a public works program may have to be provided to alleviate the problem. He also advocated the assumption by the schools of the responsibility to provide vocational and educational counseling for out-of-school young people until they are 21.

High government officials also attested to the seriousness of the problem. Vice President Lyndon B. Johnson, at a dinner meeting, maintained that the young person who drops out of school in this country is just as illiterate when measured against the needs of young people in our society as the boy or girl in Asia who never gets to school.

At a luncheon meeting Secretary of Health, Education, and Welfare Abraham A. Ribicoff emphasized the importance of local experimental programs in schools in underprivileged areas. Secretary of Labor Arthur J. Goldberg stressed the part played by racial discrimination in keeping many young people from getting the kind of education, training, and jobs they need. "If you want to do something for your country," he said, "stop discriminating." Attorney General Robert F. Kennedy, in a speech read for him, stressed the connection between unemployment and youth crime, and called for a broad concentrated effort to "narrow the gap between the legitimate aspirations of our youths and the opportunities available to them."

Ewan Clague, Director of the Bureau of Labor Statistics, Department of Labor, gave a picture of the size of the problem: 450,000 boys and girls between the ages of 16 and 20 reported themselves out of school looking for work in October 1960, about 265,000 of them in the 15 cities on which the conference focused. Reporting on studies showing that school drop-outs experienced three to four times as much unemployment as high-school graduates, he advocated the development of combination study-work programs for young people as well as efforts to impress upon them the importance of quality performance.

Speakers from labor and industry

also expresed concern over the problem; and administrators of large city school systems pointed to the obstacles of insufficient staff and money impeding efforts to cope with the situation.

Thirteen workgroups spent three 3-hour sessions seeking solutions. In summarizing their recommendations at the final meeting, Roy Sorenson, director of the YMCA of San Francisco, found 12 common denominators:

1. Strengthening the schools—in regard to curriculum, teacher training, counseling and guidance, visiting teachers and psychologists, identification of drop-outs, the provision of work experience, smaller classes, preparation for reentrance into school, and parent education.

2. Extension of special employment services for youth.

3. Coordination of schools and employment services.

4. The provision of job opportunities for beginners.

5. Action by labor and industry in behalf of youth.

6. Efforts to improve youth's self-image through opportunities for meaningful activity in cultural and community affairs.

7. Reduction of job discrimination against race and age.

8. Government financial aid and leadership for youth programs, including the creation of an urban service corps of youth.

9. Organization for the community's acceptance of responsibility.

10. Efforts to awaken public awareness to the problem.

11. Research for facts to energize action and define the problem, neighborhood by neighborhood.

12. Followup of the conference in various ways, especially by each representative taking the initiative to get something started in his own community.

—K. C.

Conference on Mental Retardation

Social services for mentally retarded children and their families was the focus of a national workshop on mental retardation for social workers, held April 3–7, in Miami Beach. The participants were social workers employed in diagnostic and evaluation pediatric centers for mentally retarded children in the maternal and child health programs of 32 State health departments. The conference was sponsored by the Florida State Board of Health; the Developmental Evaluation Clinic, Dade County Department of Public Health; and the U.S. Children's Bureau.

The workshop came about in recognition of the expressed needs of these social workers and the recommendation of the technical advisory committee to the Children's Bureau on clinic programs for mentally retarded children. While clinic teams have met on a regional basis from time to time and thrashed out mutual problems, this was the first time clinic social workers from all parts of the country have been convened.

The keynote speaker for the workshop was Edith Baker, chief of social service, Bureau of Maternal and Child Health, District of Columbia Department of Public Health, who placed social workers' activities in these clinics within the framework of the overall maternal and child health program, stressing preventive as well as treatment services.

The workshop considered three subjects. The discussion of the first, clinical social-work practice, brought out the realization that areas needing further emphasis and study were the family-centered approach, groupwork with parents, waiting lists, and selection of priorities in clinics seeing many children.

The second subject was the use of social-work skills to develop community resources for mentally retarded children in both urban and rural communities. The identification of general concepts of the development of community services was followed by specific examples of how they were applied, such as the extension of services by a central clinic to residents of adjoining counties.

The third focus of discussion was on research studies of social factors influencing mental retardation and the effect of social work intervention on social malfunction. The discussion of this went into the determination of what questions were researchable and how to go about setting up a research design. Out of this part of the workshop came an expressed need for further smaller workshops for persons primarily interested in exploring this subject further and for the establishment of a clearinghouse to make it possible for comparable research studies to be started in more than one clinic.

Other recommendations made by the group were for yearly workshops for the entire group and smaller sectional meetings on such subjects as groupwork with parents and teaching of other professional personnel.

—Mary E. Watts

For Migrants

A uniform personal health record form for migrant agricultural workers and their families has recently been produced by the Public Health Service and distributed to State health departments, from which they can be secured by local and voluntary agencies. The form was recommended by the Association of State and Territorial Health Officers at their 1960 conference in San Francisco last October.

The cover of the record provides space for the migrant's name, home address, sex, and birthdate or age. A note in English and in Spanish advises him to show the record whenever he goes to a doctor or a nurse. A note to physicians and nurses requests them to enter pertinent information and return the record to the bearer.

The entry sections of the form provide space for records of immunizations, laboratory tests and results, obstetrical history, and important clinical conditions. In the last two sections, the name and address of the person making the entry are requested.

The forms, 10½ by 4 inches, have space on both sides for other information pertinent to the migrant's health. Folded, they can be carried in his billfold or pocket.

Social Workers

On December 1, 1961, the Academy of Certified Social Workers, a new arm of the National Association of Social Workers, will begin certifying social workers who meet the qualifications set up in a national certification plan developed by the association at the request of its membership. Early this spring the academy began mailing application blanks to the association's 28,500 members. Some 10,000 aplications were filed during the first month.

The National Association of Social Workers now requires a master's degree in social work to join. Most members will be eligible for certification on December 1 if they have had both 2 years

of membership in the association and 2 years of paid employment as a social worker. Other association members on that date will have 2 years to meet those conditions, but persons entering the association later will have to meet more extensive requirements. According to present plans, the criteria for certification will eventually include measures of competence as well as education and experience.

The association has also announced its intention to continue work toward the passage of State laws providing for legal regulation of social work practice.

For Health

The Boston area has the highest ratio of physicians to population among the 17 metropolitan areas with populations of a million or more, according to a health manpower report issued by the U.S. Public Health Service. In the Boston-Lowell-Lawrence metropolitan area, where the ratio is highest, there were 207 active non-Federal physicians per 100,000 people in mid-1959. The San Francisco-Oakland area ranked second with a physician-population ratio of 199, and the New York-northeastern New Jersey area, with a ratio of 189, third. Lowest ratio in these great metropolitan areas was 111, found in Detroit area.

In 157 metropolitan areas with fewer than a million people, the ratios of physicians to population ranged from 459 per 100,000 persons (Ann Arbor, Mich.) to 39.

In the larger metropolitan areas, the proportion of physicians in private practice was greatest—77 percent—in the New York-northeastern New Jersey area. The Baltimore area had the greatest proportions in hospital service, teaching, and other salaried positions—38 percent.

Entitled "Health Manpower Source Book, Section 10: Physicians' Age, Type of Practice, and Location," the report (PHS Publication No. 263, Section 10) is available from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Price 55 cents.

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The Mental Retardation Training Center at Tulsa, Okla., a special project of the Children's Bureau and the Oklahoma State Department of Health, gave its first course for nursing instructors February 20–24, 1961. Twelve instructors from Oklahoma schools of nursing attended the course, which was composed of lectures, discussions, and demonstrations concerned with the normal growth and development of infants and methods of detecting deviations, the effects on the parents of diagnosis of retardation in a child, methods of parent counseling, the necessity of cooperation between hospital personnel and public health nursing services, the kinds of community facilities needed to serve retarded children and their families, and the use of films, publications, and other teaching tools in training personnel to work with the retarded. Included was a team demonstration of an evaluation of two children.

The course was planned by a committee representative of the Oklahoma State Board of Nurse Examiners, the Oklahoma League for Nursing, The Tulsa-City County Health Department, the Oklahoma State Department of Health, and the Federal Children's Bureau.

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A "total-care" attack on long-term childhood diseases overlapping a number of medical specialties has been underway in a clinic of the University of Michigan Medical Center at Ann Arbor, where approximately 600 patients have been helped during the first year. Launched in early spring 1960, the total-care clinic, which is held weekly, permits simultaneous study of a child's ills by a number of specialists.

An extension of the team-treatment pattern used at the medical center for burn victims and patients with cleft palate, the new approach includes specialists in pediatrics, neurology, orthopedics, physical medicine, and arthritis, and in other fields as needed. A medical social worker is also in the group.

Peace Corps

By late spring, the Peace Corps (see CHILDREN, May–June 1961, p. 114) had specific projects in preliminary stages of operation for three newly developing countries and requests for Corps volunteers from 24 nations. The Corps plans to send 28 surveyors, geologists, and civil engineers to Tanganyika in early October to map out roads in the barren bush country. A 7-week training course, now underway at a western university with climatic and geographic conditions resembling those in the project country, includes 4 hours a day of Swahili, the common language of Tanganyika.

Another group of 64 volunteers is slated to begin work on rural development projects in Colombia in the fall of 1961. About twice the number of recruits needed are being trained by Rutgers University in Latin American politics and culture, drilled in language, and refreshed in the latest of agricultural techniques. Those trained but not selected will remain in the Peace Corps reserve.

Scheduled to begin arriving in the Philippines during the first part of November are 300 Corpsmen who will assist local elementary school teachers in English instruction and in general science subjects.

Trainees for these projects first passed examinations for Peace Corps applicants held in May and June, which tested, among other things, competence in technical fields or special skills.

Other projects in the planning stage include those growing out of an eight-country tour of Asia and Africa by Corps Director R. Sargent Shriver. Of 3,500 volunteers requested, Nigeria alone asked for 1,200 and Ghana, 300.

Social Work Manpower

Completed figures from a survey of social welfare personnel carried out in the spring and summer of 1960 showed a total of 116,000 persons holding positions as social welfare workers in 1960, a rise of 42 percent since 1950, the last year a national survey was made. The survey was conducted by the Bureau of Labor Statistics of the Department of Labor in cooperation with the Department of Health, Education, and Welfare and the National Social Welfare Assembly. (See CHILDREN, March–April 1960, p. 77.)

The survey also showed that salaries of social workers had appreciably increased during the period, the national average of 1960 being $5,220, a 76-percent rise since 1950. (During the period the Consumer Price Index rose 23 percent.)

Among the 116,000 social welfare workers (including some 10,000 recreation workers), 64 percent were employed by government agencies, the great majority of them by State and local agencies. Public assistance, with 30 percent of the workers, and child welfare, with 21 percent, absorbed the

largest portion of workers. Sixty-two percent of the total were in direct service positions.

Though only 25 percent of all social welfare workers had graduate degrees, 50 percent had had some graduate study, 33 percent in a school of social work. However, 29 percent of the total had not achieved a bachelor's degree.

The overall report of the study, "Salaries and Working Conditions of Social Welfare Manpower in 1960," is available from the National Social Welfare Assembly, 345 East 46th Street, New York, 17, at the price of $1.75.

Besides data on employment characteristics, education, work experience, and salaries, the survey also includes information on employment practices and supplementary benefits. The data were gathered from 531 counties selected as sampling areas and through a 100-percent survey of social workers in federally aided programs.

Detailed data collected from this survey of social welfare workers in federally aided programs are being released in separate reports by the Department of Health, Education, and Welfare. A joint report from the Bureau of Public Assistance and the Children's Bureau shows a 74-percent rise in social welfare workers in public child welfare programs during the decade. It also shows that the proportion of child welfare workers with full professional education in social work had gone up from 20 to 26 percent, and that the proportion lacking bachelor's degrees had dropped from 16 to 9 percent. However, the proportion of child welfare workers with no graduate social work education rose from 40 to 46 percent. The median salary for a caseworker in child welfare in 1960 was $4,553, representing a 68-percent rise since 1950.

In public assistance the total number of social welfare workers rose from 29,900 to 34,500. In the supervisory group the proportion with full professional education in social work increased from 10 percent to 13 percent. However, the proportion of caseworkers with full professional education dropped (from 2 to 1 percent) as did the proportion of caseworkers with some graduate social work study (from 17 percent to 11 percent). The proportion of caseworkers with no college degree—about a third of the total—remained about the same. Public assistance salaries also increased, so that only 16 percent of the caseworkers were receiving $3,600 or less, compared with 98 percent in 1950.

Data on social welfare workers in public health programs will be published by the Public Health Service in the near future.

Federal Legislation

Two measures broadening the scope of the aid-to-dependent children program for a period of 14 months were among a group of amendments to the Social Security Act passed by the 87th Congress, with the effective date of May 1. The two actions brought under ADC coverage (1) children of unemployed parents, and (2) children who are removed from their homes by courts of competent jurisdiction because of inadequate protection and care and are placed in foster family homes.

The amendment authorizing the Federal-State ADC program to be extended to children of unemployed parents now allows needy children to receive assistance while both parents remain in the home—a situation not previously possible if one of the parents was employable. The usual breadwinner in such families is, however, required to use the State employment services, and the State has the option to exclude families receiving unemployment compensation. State agencies administering the program must encourage the retraining of individuals capable of being retrained through arrangements with State vocational education agencies.

The foster-care amendment modifies the provision which has limited ADC coverage to needy, dependent children who are living with their parents or with specified relatives. Now, Federal matching of funds is authorized for State payments on behalf of children who have been placed in foster family homes after May 1, 1961. The children must have been eligible for assistance under the program before placement and have received aid for the month in which removal proceedings were begun. Included in the amendment is the requirement that the State provide for "development of a plan for each such child (including periodic review of the necessity for the child's being in a foster family home) to assure that he receives proper care and that services are provided which are designed to improve the conditions in the home from which he was removed . . ." In placing the child, the administrators of the aid-to-dependent-children program are required to use "to the fullest extent practical" the services of personnel in the public child welfare program.

The Senate committee reporting on the amendment before its passage noted that some States "have placed in operation statutes terminating payment when a child's home is found unsuitable because of immoral or negligent behavior of the parent." (See CHILDREN, November–December 1960, p. 241, and January–February 1961, p. 36.) The committee report expressed the opinion that remedial action on behalf of the child often was not possible and that this situation could have been avoided if "assistance under the program were available for the care of the child in a foster family home."

In another amendment Congress postponed from July 1, 1961, to September 1, 1962—for States with statutory impediments to compliance—the effective date of a ruling made by the Department of Health, Education, and Welfare, under former Secretary Arthur S. Flemming, to cut off Federal funds to States that deny ADC payments to children in "unsuitable homes" without otherwise providing for the care of the children. (See CHILDREN, March–April 1961, p. 73.)

Another amendment to the act raises the authorization for Federal participation in the financing of grants for training public welfare personnel for public assistance agencies from 80 to 100 percent, during the period July 1, 1961, through June 30, 1963. (No appropriation has been made for this type of activity since it was first authorized in 1956.)

White House Conference

The final collection of papers from the 1960 White House Conference on Children and Youth, "Values and Ideals of American Youth," edited by Eli Ginzberg, came off the press in late May. (Columbia University Press, New York, price $6.) Composed of selected papers prepared for the conference and addresses delivered at the Washington meetings, the book is divided into three parts: I. "Development and Adaptability"; II. "Problem Areas"; and III. "Values in Transition."

Part I contains papers on the possible effects of a changing world on

young people's development and opportunities, and the qualities necessary for healthy adaptation.

Part II contains papers on the special problems confronting or presented by some young people today—poverty, juvenile delinquency, racial discrimination, reckless driving, and pornography.

Part III includes papers on the methods and climate required for the teaching of values and responsibility, and the nurture of creativity.

Included among the 22 authors are a physical scientist, psychiatrists and other physicians, psychologists, educators, a lawyer, sociologists, social workers, public health educators, and religious leaders.

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The American Jewish Committee, Institute of Human Relations, has recently issued a pamphlet, "Guidelines Toward Human Rights," composed of all the recommendations on human rights, intergroup relations, and related issues from the forums of the 1960 White House Conference on Children and Youth. The recommendations are presented under categories designed to be useful in programing: civil rights, community organizations and services, discrimination in education, educational policy, employment, health, housing, intergroup relations, mass media, recreation, research, and youth participation in community affairs. The pamphlet is available from the committee, 165 East 56th Street, New York 22. (Price 20 cents, less, in quantity.)

Juvenile Delinquency

In order to coordinate and broaden Federal efforts to help States and localities combat juvenile delinquency, President Kennedy in mid-May established by executive order the President's Committee on Juvenile Delinquency, composed of the Attorney General, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, with the Attorney General as chairman. The President also directed the establishment of a Citizens Advisory Council of not less than 12 or more than 21 persons to work with the Committee.

The executive order charged the President's committee with four functions relating to juvenile delinquency and youth crime.

- To review, evaluate and promote the coordination of Federal activities.
- To stimulate experimentation, innovation, and improvement in Federal programs.
- To encourage cooperation and information exchange among Federal, State, and local organizations with similar interests.
- To recommend measures to Federal departments and agencies for more effective prevention, treatment, and control.

The Citizens Advisory Council, whose members and chairman are to be designated by the Attorney General, is to be composed of persons who are recognized authorities in professional or technical fields, or leaders in programs concerned with juvenile delinquency or youth crime.

David L. Hackett, a special assistant to the Attorney General, has been named executive director of the President's committee. Lloyd E. Ohlin, professor at the New York School of Social Work, has been appointed special consultant on juvenile delinquency for the Department of Health, Education, and Welfare.

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Results of a recently completed study to gauge the effects of training school experience on personality, carried out at the Michigan State Girl's Training School, showed that 70 percent of the girls tested showed fewer liabilities associated with mental health after a year in the school, while 30 percent showed an intensification of such liabilities.

The study involved testing of 120 girls within the age range of 12 to 17 years both on admission and after a year with a questionnaire measuring personality liabilities such as: behavioral immaturity, emotional instability, feelings of inadequacy, physical defects, and nervous manifestations. Also measured were such assets as close personal relationships, interpersonal skills, social participation, satisfying work and recreation, and adequate outlook and goals. Sixty-five percent of the girls tested showed an increase in assets associated with mental health, whereas 35 percent showed a decrease in such assets.

The study was carried out by Merle Smith, staff psychologist, and Norman G. Tolman, supervisor of psychological services, who suggest that its results indicate the need for a testing instrument to identify girls at admission to the school who are likely to be damaged by the training school experience.

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A project integrating vocational training and treatment of emotionally disturbed, delinquent boys at Children's Village, a voluntary institution for the treatment of juvenile delinquents in Dobbs Ferry, N.Y., recently received funds from the Office of Vocational Rehabilitation for the first year of operations out of a grant of some $209,500 for a 5-year period. The participants are boys with limited education, lack of previous vocational direction, a belief that the good things in life are unobtainable, behavior standards that are unacceptable, inability to delay satisfying immediate wants, and lack of self-confidence.

Under the project the boys will continue to receive the integrated service after they return home. Designed to include continuous evaluation of its effects, it will test whether vocational rehabilitation, by enhancing the boys' potential for economic productivity, can help them to acquire more self-respect, stimulate them to want more education, and reduce their antisocial activity.

Child Welfare

In Maryland, less than a third of the 4,409 children in foster care were born out of wedlock, and about 64 percent were living with one or both parents when coming into such care, according to a statewide study on child welfare recently completed by the State department of public welfare. Entitled, "Maryland's Public Child Welfare Programs," the report covers data on foster care, adoptive, protective, and after-care services, both public and private.

Among other facts brought out were:

- As of March 31, 1959, nearly 10,000 children were receiving child welfare services. A little more than 18 percent received service from private agencies, the rest from public. More than a half of the welfare total was in foster family or adoptive homes.
- Of the 1,209 children in protective service, about two-thirds came from the counties rather than the city. Out of the 788 from the counties, 610 were white; while the city total of 421 included 87 white children.
- More than three-fourths of the 436 children receiving after-care service on their return from training school for delinquents were from families who

were not receiving public assistance.

The study data will be the springboard for special studies, such as on children in foster care over a number of years, with implications for ways to reach families earlier and for improving the chances for children to remain in their own homes.

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The Citizen's Committee for Children of New York, Inc., has launched a campaign to secure a protective casework service for neglected children and their parents within the child welfare program of the New York City Department of Welfare. In a report, "Protecting New York City's Children," released at the opening of the campaign, the committee argues that the right to pursue a complaint must be lodged in a public department since "citizens understand legal authority delegated to a public department and also know that provisions exist to protect their rights." In 1960, according to the committee, there were 3,564 neglect petitions before the New York City courts, many of which might have been prevented if service had been provided to the family earlier.

The report, prepared by Alfred J. Kahn, is to be included as a chapter in a book "Community Strategy and the Delinquencies," to be published by the committee late in 1961.

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The Kentucky Department of Child Welfare is in the process of setting up a "child accounting system" including all children receiving welfare services through the department. This system will serve as a basis for planning for each child. Initial accounting and planning began with all of the children in foster care.

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West Virginia has developed comprehensive schedules for the study of children in foster care within that State. Carried out by the State department of public assistance, the study is part of the groundswell of stocktaking among the Nation's child welfare agencies, generated by the Maas-Engler study under the auspices of the Child Welfare League of America. (See "No Homes of Their Own," by Wayne Vasey, CHILDREN, July–August 1960, p. 155.) Of particular concern in the West Virginia study are the children without meaningful relationship with their own families and for whom foster care has become a permanent way of life.

Analysis of data from the schedules—each of which will be completed by the child welfare worker assigned to the child—will answer such questions as these about children in foster care:

How long have they been in such care? Which children should or can be adopted? Which ones are different from those being adopted and how are they different? What can be learned about the unadoptable that will serve as guideposts in preventing others from growing up without families of their own?

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Public and voluntary agencies are taking part in a new study of characteristics of children receiving child welfare services being conducted by the Children's Bureau in cooperation with the Child Welfare League of America. A previous study by the Bureau covered all children receiving child welfare services in 45 States through public agencies only. Findings of this survey were published in 1960. (See "Children Who Receive Services from Public Child Welfare Agencies," Government Publications, inside back cover.)

Guides and Reports

THE PEDIATRICIAN'S ROLE IN PREVENTING DELINQUENCY. American Academy of Pediatrics, 1801 Hillman Avenue, Evanston, Ill. 1960. 32 pp. Single copies free from the Academy.

This discussion of specific ways in which a pediatrician can assist in the study, treatment, prevention, and understanding of juvenile delinquency, identifies the pediatrician's major contributions in the area of prevention as derived from his roles as an adviser to parents, community worker, teacher, and researcher.

THE CASEWORKER; person with value. Mary Overholt Peters. American Public Welfare Association, 1313 East 60th Street, Chicago 37. Series on Services and Training, III. 1960. 26 pp. 75 cents. Discounts on quantity orders.

One of a series planned to help State and local public welfare agencies in effective implementation of recent amendments to the Social Security Act, this pamphlet discusses ways in which the public assistance worker can use the client-worker relationship to help strengthen family life.

HELPING PARENTS OF HANDICAPPED CHILDREN. Children's Hospital Medical Center; and Child Study Association of America, 9 East 89th Street, New York 28. 1961. 40 pp. $1.25.

Proceedings of a 1959 conference focused on preventive mental health methods for chronically ill or disabled children and their families, including papers on the psychiatric implications underlying parental concern for handicapped children, and on community planning for their parents.

PROFESSIONAL SALARIES IN MENTAL HEALTH CLINICS AND HOSPITALS. Ralph Anderson, Editor. Des Moines Child Guidance Center, 1206 Pleasant Street, Des Moines, Iowa. 1960. 12 pp. Single copies, 35 cents; 10 or more, 25 cents each.

Results of a survey of salaries offered professional workers in 213 mental health facilities, inpatient and outpatient, with full-time staffs including at least a psychiatrist, a clinical psychologist, and a psychiatric social worker, are reported for the 50 states of the United States, Canada, and Puerto Rico. Data, covering filled and unfilled positions in these three professions and other related positions, are compared with a previous survey.

BOOK NOTES

RECENT DEVELOPMENTS IN PSYCHOANALYTIC CHILD THERAPY. Joseph Weinreb, editor. International Universities Press, New York. 1961. 178 pp. $5.

A collective discourse on the mutual enrichment of psychoanalysis and child guidance, this book presents the work of 17 participants in a symposium sponsored by the Worcester Youth Guidance Center in Massachusetts.

The first part comprises a paper by Anna Freud on adolescence—which she calls the "stepchild of psychoanalytical theory." She also contributes to the book's second part, on the child guidance clinic as a center of prophylaxis and enlightenment, in which other participants discuss work with physicians and with teachers.

In part 3, the papers treat aspects of diagnosis and selection, including the process of intake as an aid in the determination of treatability; and the use of prediction in longitudinal study.

The fourth part concerns selected treatment situations: the treatment of under-fives by way of their parents; the application of psychoanalytic knowledge to children with organic illness; and borderline states in childhood and adolescence.

THE INFORMED HEART; Autonomy in a Mass Age. Bruno Bettleheim. The Free Press, Glencoe, Ill. 1960. 309 pp. $5.

Concerned with the danger of an abrogation of spontaneity and of individual decision-making in an increasingly complex and comfort-producing society, the author of this book draws on both his professional experience as a child psychologist and his personal experience in a Nazi concentration camp more than 20 years ago in suggesting the dangers to individual happiness and to a free society in the loss of personal autonomy. In a day of scientific progress, he warns, man needs a much more highly integrated personality than in a period of less rapid change and fewer choices. Without this, he suggests, the seductiveness of mass persuasion and the tendency to leave decisions to the experts weakens inner controls and the ability to achieve satisfactions—"a condition which may lead to dangerous inertia or to explosions of instinctual violence."

Presenting his concentration camp observations as evidence that environmental stress can change the personality of a mature adult—either for better or for worse—he reviews these in an effort to identify those factors in personality which enable man to stand up in any environment, even one created for the purpose of dehumanizing the individual. While his own chief concern as a prisoner was to survive without changing as a person, in the face of a daily regimen of indignities, hunger, and fear, his chief device for doing this was to maintain his professional interest in studying human behavior, by observing his fellow prisoners and trying to learn why some managed to keep their personalities intact and others disintegrated quickly.

Those whose personalities held up, he reports, were not those who psychoanalysts would have predicted would be strongest under stress, but those who in spite of possible neurotic traits could maintain the interests from which they had derived self-respect, whether this was a religion or a strong intellectual interest. What seemed to matter most to the maintenance of integrity, he says, was whether or not the prisoner was able to carve out some freedom of action and thought for himself, however small. What produced change, whether for good or bad, he observed, was a person's own behavior, for "how a man acts can alter what he is."

THE TEEN-AGE YEARS; a medical guide for young people and their parents. Arthur Roth, M.D. Doubleday & Co., Garden City, N.Y. 1960. 288 pp. $3.95.

Why a teenager may act like an exhausted old man one minute and turn into a bundle of energy the next, or why a strapping football player may keel over while waiting for a routine immunization shot are among the enigmatic features of adolescent behavior unraveled in this guidebook for the laity. At the outset, the author describes the teenage years as a "second infancy," in which the search for personal identification is accepted by "the impatient reaction of youth on the threshold of adulthood."

The author advises on the gamut of medical, paramedical, and behavioral topics related to adolescence—from acne to late hours—drawing heavily for illustrations on his professional experience in a clinic for adolescents. Following a detailed account of expected physical changes accompanying growth and development, he calls attention to the wide range of differences within the concept of normality and warns against setting up impossible goals of physical and mental attainment for young people.

Anxieties among teenagers, he points out, are commonly caused by fatigue—often brought on by heavy social and school involvements—weight, and skin disorders.

The author, a founder-director of the teen-age clinic, Kaiser Foundation Medical Center, Oakland, Calif., maintains that rapport with teenagers can best be established by a family doctor.

OUR OBSTETRIC HERITAGE; the story of safe childbirth. Herbert Thoms, M.D. The Shoe String Press, Hamden, Conn. 1960. 164 pp. $4.75.

Tracing the advance of obstetrics from folklore to science, the author, a medical historian and obstetrician, sketches the biographies of people who helped clear the hurdles of "ignorance, superstition, and prejudice." Among them were Smellie, Semmelweis, and Oliver Wendell Holmes, who believed puerperal fever to be infectious long before the theory was widely accepted.

Chapter subjects include the renaissance of obstetrics, the "with-women," the great teachers of the 18th century, and the cesarean section, which the author calls the greatest as well as the oldest operation.

Stellar American contributions in this specialty were in obstetric teaching and hospital care, the author points out. Together with such medical breakthroughs as the discovery of antibiotics and the Rh blood factor, they helped reduce maternal mortality in the United States from 58 cases per 10,000 live births in 1935 to 6 in 1953.

IN THE JOURNALS

Training Schools

A "fever" rather than a disease, juvenile delinquency has sources deep in the culture and morals of the community, writes Povl W. Toussieng, M.D., in the March 1961 quarterly issue of *Federal Probation*, and for that reason success with delinquent youth in correctional schools hinges largely on cooperation of the community, in turn a corollary of the community's understanding. ("The Role of the Psychiatric Consultant in a State Training School.")

The author, who is psychiatric consultant with a boys' industrial school in Kansas, comments on the rash of appointments of psychiatric consultants in training schools, sometimes made without adequate planning. He sets out guidelines for such schools' selection and use of psychiatric consultants, advising first that the school consider its goals. Is it reeducational? Then the consultant can contribute less—and the psychologist more—in setting up treatment targets and helping staff understand the child, than if "treatment" were the schools objective.

In the author's opinion, the psychiatric consultant could do more in schools with the clinical staff to translate technical advice into lay language for other workers. Also he asserts, psychiatrists of the psycho-analytic school, concerned with the interplay of many factors, are suited for schools with a multipronged treatment program rather than for those with a single rehabilitation approach. The psychiatrist in any case should be familiar with the community's subcultures as well as experienced in child psychiatry and juvenile delinquency, he maintains.

Seven Years of Fluoridation

Fluoridation of the water supply in Corvallis, Oreg., is credited with a sharp drop in the rate of dental caries among children there of 5 to 12 years of age, by investigators reporting in the April 1961 issue of *The Journal of Pediatrics*. ("Dental Caries Experience of School Children in Corvallis, Oregon, After 7 Years of Fluoridation of Water," by Gertrude Tank, D.D.S., and Clara A. Storvick, Ph. D.) At the time of the study, more than twice as many children in this age group were free from caries as before fluoridation. This effect was noted for teeth developed both before and after the fluorine content was raised.

The investigators point out that maximum effects on the children's teeth will not be apparent before 12 years of exposure to fluoridated water, but the beneficial results after only 7 years are highly significant.

Clinic-Centered Services

The practicality—in underdeveloped areas—of building child health services around a pediatric clinic rather than using the conventional, prevention-focused pattern used in the United States is described by Alfred Yankauer, M.D., in the March 1961 issue of *The Journal of Tropical Pediatrics and African Child Health*. ("Prospectus for a Child Health Service Built Around Pediatric Clinics.") The author, who is head of the Bureau of Maternal and Child Health of the New York State Department of Health, points out that the treatment-focused scheme recognizes conditions in countries such as India, with its shortage of medical manpower for treatment, let alone of preventive health services for children.

When he was in India as WHO visiting professor of child health at Madras Medical College, the author found that the mothers were strongly motivated to seek help only when their children were sick. This, coupled with the large number of acute episodes of illness among children there, make the personnel of a pediatric clinic ideally suited for health supervision and for introducing the family to the child health program, he says.

In presenting guidelines for a clinic-centered plan, the author advises having physicians and "health visitors" give health counseling at every opportunity—during medical examination and treatment, group meetings with mothers, at clinic or health center, and during home visits—thus making it the link for all activities.

Following a step-by-step account of the way such a program operates in India—from the mother's pregnancy through the child's first year—the article concludes with the observation that success lies in continuing assessment of whether program operations follow the original plan and in the willingness to modify the program if indicated.

Group Counseling

As a means of reaching a larger number of parents of its adolescent clientele without cutting into the time spent with these young people, a casework agency tried counseling parents in groups. This experience is reported in *Social Work* of April 1961 ("Group Counseling With Parents in an Agency Serving Adolescents," by Erwin M. Laibman). The author is a caseworker in the agency, the Youth Service of Cleveland, Ohio, which focuses on the emotional problems of adolescents.

Two groups of middle-income, suburban families, each group composed of parents of six adolescent clients, were selected on the basis of, among other criteria, relative family stability, and the absence of gross pathology. Brought together by such problems as parental control or the adolescents' school performance, disapproved choice of friends, or sexual interests, they met for an hour and a half each week, the first group six times and the second, eight. The parents also had individual interviews with the adolescents' caseworker.

The author tells about the way the groups were oriented to the group experience—with subjects such as the family structure or adolescent value systems—and gives highlights of group interaction. There were gains in arousing empathy and in unveiling fallacious thinking about teenagers. For example, most of the teenagers seen by the agency were misinformed or ignorant of sex facts rather than possessed of sophisticated accumulation of knowledge, as thought by the parents.

According to the caseworkers, the parents learned more about themselves and found relief from tensions in universalizing specific problems, the authors report.

READER'S EXCHANGE

RADINSKY: ***What about the parent?***

Elizabeth K. Radinsky's paper entitled "Children of Discharged Mental Hospital Patients" [CHILDREN, May–June 1961] might leave the impression that the recent rise in discharge rates from mental hospitals has opened a virtual Pandora's box of complex problems for child-placing agencies. That staff members of agencies responsible for foster home placement of children would be concerned with the possible ill-effects of the return of their charges to parents who are former mental patients is understandable. Yet legitimate concern might be expressed, as well, for the discharged patient to whom the return of his children is denied.

Miss Radinsky states that ". . . for the child the parent is present whether or not he is on the scene. . . ." It is this writer's observation, based on experience with hospitalized psychiatric patients who are parents of young children, that for the parent, too, the child is present whether or not he is on the scene. If discharge of the patient can reasonably be anticipated, there seems to be merit in attempting to maintain the child's relationship with the ill parent during the period of hospitalization. Eugene A. Weinstein comments that for children in foster placement, "Regular contact with natural parents is a prerequisite for identification with them." ("The Self-Image of the Foster Child," Russell Sage Foundation, New York, 1960, page 51.) I have observed that when hospitalized patients are visited regularly by their children, the visits seem to be quite meaningful both to the child and the patient.

Perhaps the question to be posed is this: Do we want to bend every effort toward reuniting all family members once the patient is able to return home? If so, cooperative planning by the child-placing agency staff, the hospital staff, and family members is indicated. There should be no "closed ranks," with the patient excluded. Of course the nature of the patient's symptomatology, and the severity of the illness must be considered. But concerted effort and flexibility may increase the chances that children and parents can be reunited, to their mutual benefit, when the period of the parent's hospitalization is over.

Leila Calhoun Deasy
Associate professor of social research, National Catholic School of Social Service, Catholic University of America.

Author's response

If writing from the vantage point of the child-placing agency appears to be less empathetic with the discharged mental hospital patient than with his child, I want to thank Dr. Deasy for emphasizing the patient's need for his child. We have come to know well the meaning of child and parent to and for each other and so have come to a recognition and awareness of the limits of foster care in and of itself, even of foster family care. In our agency, these have been compelling factors in our constantly seeking ways of helping children and families to remain together or to be reunited as early as possible, the implications of which are borne out in the Weinstein study. Our intake studies and discharge plans attest to these efforts.

However, we cannot ignore the fact that 40 percent of our children in care show serious emotional problems and impaired personalities. Most of these children lived within seriously upset, malfunctioning families for protracted periods preceding placement. This in no way diminishes the advisability of maintaining contact with the parent. Whether contact should be maintained through visits of the child to the hospital or through an intermediary such as another parent or relative or, in the absence of these, the worker, has to be determined by the child's ability to cope with the shock of seeing his parent in a mental hospital setting, as well by the emotional state of both parent and child.

Dr. Deasy agrees that reunion of children with discharged mental patients has to be geared to the welfare of each and of both together. Premature discharge of a child needing special care may jeopardize the patient's recovery and the wholesome functioning of the family, as well as set back the child.

Rather than a "Pandora's box," we see the progress in treatment of the mentally ill as opening untold possibilities for the return of many children to their own homes and deterring total breakup of families. Protagonism for child *or* patient, however, can only defeat "family." Cooperative planning and mutual comprehension of the needs of the respective charges must be coupled with adequate services while the child and patient are in care and when they are together again as a family.

Elizabeth K. Radinsky
Director, Foster Home Division, Jewish Child Care Association, New York

CASE CONFERENCE: ***A community failure***

I read the entire piece, "Case Conference" [CHILDREN, May–June 1961], through the eyes of a conservative and critical community fund donor and found myself squirming. I would be at a loss to explain, let alone defend, the situation as it unfolded in the case story.

To be sure, I would like to know more about the people in the family described, a lot more about the community, and I would like to hear what the social workers and doctors who knew the family have to say. However, even allowing for mitigating circumstances and understandable difficulties in providing the needed services, this family reflects a certain amount of failure on the part of the community. I was glad to see that the commentators did not duck that.

An obvious factor, of course, is the lack of coordination of effort and services. However, before coordination there must be a sense of *responsibility*—as the subtitle of the article ("Whose Responsibility?") clearly implies. The most shocking fact, however, is that no one in the community apparently felt any real responsibility for this family.

Recently the 15-year-old grandson of

a friend of mine was attacked in a Connecticut town by a group of older boys, and so seriously injured that he spent 2 weeks in the hospital and may still require major surgery. The question is whether any *one person* or any one group in that town will have enough righteous indignation and "umph" to do anything about the conditions that produced such behavior.

Coordination of services does not start, will not work, and cannot last unless it emerges from, operates under, and is sustained by a strong sense of responsibility expressed by *individual* citizens. The community which was the setting of the case story obviously needs a reawakening of its sense of responsibility. It makes little difference who sounds the challenge, provided he has the respect of his fellows. Once the call has been sounded, the men and women who have community organization skills and a sound philosophy can help to guide developments.

The basic need in both this and the Connecticut community is for a few people of character to care enough to arouse themselves and others out of their complacency. No amount of bright community "schemes" can take the place of an aroused citizenry in getting an agency started, keeping agencies in team play, and (with the help of good professional skill) keeping long-range planning in operation.

Sometimes one "good failure" such as the one described can start a chain reaction of improvement, if it is put to good use and is handled well.

Leonard W. Mayo
Executive Director, Association for the Aid of Crippled Children, New York

COHN: *A lesson from abroad*

Helen Cohn's article describing the coordinated well-child and pediatric services provided by the American Joint Distribution Committee in Teheran is evidence that when the pieces of a service are well put together, the whole is greater than the sum of parts. ["A Family Health Program in Teheran," CHILDREN, May–June 1961.] Moreover, the gains achieved are great when the frontline staff-workers (in this case the behyars or public health nursing assistants) know where to go and what to do when they get there.

My experience with public health nursing service in maternal and child health programs in the United States has led me to believe that we do not yet have good enough definitions of the correct composition of caseload, nor clear enough definitions as to what the public health nurse must do when she makes a home visit or sees her patients in the clinic or health center.

William M. Schmidt, M.D.
Head, Department of Maternal and Child Health, Harvard School of Public Health

MECUM: *A different approach*

As an administrator in another Eastern State school for delinquent girls, I am impressed by the apparent differences in educational and sociological backgrounds of the girls in our school and those in the State school described by Ethel D. Mecum in the March–April issue of CHILDREN. ["Bringing Training School and Community Together."] Differences in problems and opportunities are inherent in the location of the schools, one "in a small city in a small State," the other—ours—located within the capital city (population 114,167) of a State with a population of 6,039,594 concentrated in urban areas. Most of our girls come from the urban areas.

Because of these basic differences in the two schools, our approach to the public relations program and the integration of the school with the community is necessarily different. Each institution has to tackle these problems on the basis of staff, clientele, geographical assets, and limitations, as well as availability of resources, both in terms of leadership and agencies.

Miss Mecum's article spells out clearly ways in which volunteers can enrich the program of the institutions by carrying continuing leadership roles both with groups and with individuals. The question which I would like to ask is: approximately how many man-hours of staff time were allocated to work with volunteers and for community contacts? Experience has shown that unless sufficient staff time is available for training the volunteers, and for a continuing relationship of staff with them, the program is doomed to failure.

Our volunteers come from all over the State. Approximately 25 come once a week or twice a month, and in addition we have an average of 80 each month working with and for the girls in a variety of projects. The latter are generally different individuals each month who, we hope, will interpret the institution and its program positively. They come from church groups, service clubs, fraternal organizations, labor unions, and some group work agencies. Materially they have contributed gifts both large and small.

For example, in July of 1955, Sub-Junior clubs of the State Federation of Women's Clubs composed of high school girls, began coming to the institution in groups on Saturday afternoons to meet with our girls. The Sub-Junior clubs came from all parts of the State and such groups made only one or two visits during the year. For our girls it was a continuous program of service projects with which they assisted the Sub-Juniors, interspersed with parties or entertainments. The interest of the Sub-Juniors gained momentum and culminated 4 years later in the raising of $35,000 by the total junior membership department of the federation to build a playfield at the institution. Staff as well as girls have enjoyed the contacts this project afforded.

Such contacts and gifts have improved our program within the institution. However, we have only scratched the surface. The opportunities brought to the girls while in the institution may develop self-confidence, new interests, skills, and leadership qualities, but back in their local communities they may not have these opportunities. Will this then be another frustration for them, another disillusionment?

Are we in the institutional field plugging enough for the establishment of community agencies to work with the teenager before he or she becomes a delinquent? Are we who see the results of lack of parental love and supervision, the lack of early detection of personality problems, lack of organized recreation in communities, sharing our information with citizens groups? Are we helping not only to make possible opportunities for young people committed to the training schools, but also for those still uncommitted but in need?

Helen Shelcy
Superintendent, New Jersey State Home for Girls, Trenton

Photo Credit

Frontispiece, Richard Keller, Philadelphia United Fund.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

A SELECTED BIBLIOGRAPHY ON PHENYLKETONURIA. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 27 pp. Single copies are available free of charge from the Bureau.

The first listing by the Children's Bureau of selected literature on phenylketonuria, this bibliography is divided into sections devoted to testing and detection, surveys of population groups, and biochemical and genetic aspects, among others. Under each title is a distillation of the work's principal points. An index of authors is also included.

DOMESTIC AGRICULTURAL MIGRANTS IN THE UNITED STATES; counties estimated to have 100 or more at peak of normal crop season. Revised. Department of Health, Education, and Welfare, Public Health Service; Social Security Administration, Children's Bureau; and Department of Labor, Bureau of Employment Security. PHS Publication No. 540. 1960. Copies are available without charge from the Public Health Service, the Children's Bureau, and the Bureau of Employment Security, as well as from State health departments and employment security agencies.

As an aid for agencies concerned with domestic migration, this map identifies by variations in shading the degrees of domestic migrant concentration by county or groups of counties throughout the United States.

STUDY OF STAFF LOSSES IN CHILD WELFARE AND FAMILY SERVICE AGENCIES. William B. Tollen. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1960. 193 pp. 55 cents.

Through a detailed analysis of data assembled by the Children's Bureau with the cooperation of voluntary and State welfare agencies, this report answers questions on professional staff losses in family and child welfare agencies, of interest to agency executives, directors of schools of social work, and social workers. Differences in rates of turnover among the different categories of age, marital status, and training background; reasons for these workers' resignations; and what they did subsequently are discussed.

YOUR CHILDREN AND THEIR GANGS. Edith G. Neisser and Nina Ridenour. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 384. 1960. 34 pp. 20 cents.

With emphasis on the need of almost every child for participation intimately in a group of his own, this booklet discusses the meaning of these groups, the forms they may take, and the group "code." The publication also outlines constructive ways for parents to help the group and the child.

CHILDREN WHO RECEIVE SERVICES FROM PUBLIC CHILD WELFARE AGENCIES. Helen R. Jeter. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 387. 1960. 60 pp. 25 cents.

Presents facts and figures on the number of children receiving child welfare services from public welfare agencies, the results of the first of such studies since 1945. Data include the characteristics—age, sex, color, living arrangements, marital status of parent—of 220,812 children in 45 States receiving such services.

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